Request for Assistance Form

dpas your dental plans
Part of the WESLEYAN Group

Hospital cash or oral cancer

It is important that your request for assistance, where possible, has been pre-authorised prior to submission. To obtain pre-authorisation, please contact the Assistance Team on 0300 303 5065 or outside normal working hours call the Dental Helpline on 0800 525 631 (UK) or 0044 1747 820841 (outside the UK).

The admission of a request by the Worldwide Dental Emergency Assistance Scheme is at the sole and absolute discretion of the Scheme Manager.

If admitted, your request will be considered by the Scheme Manager, against the Schedule set out in the Scheme Handbook, which provides a guide to the level of Benefits to which you may be eligible.

Please ensure you have read the Scheme Rules and associated Benefit Schedule to ensure you are familiar with any limitations or exclusions that may apply to your request. A copy is available at http://scheme.dpas.co.uk/patients.

Please provide as much information as possible to ensure your request is processed efficiently and promptly.

- A Request for Assistance Form must be completed by you (and the treating dentist where specified) and must be submitted within 30 days of the incident.
- You must at your expense, provide any reports, certificates, information and evidence that is relevant to support your request.
- We may request copies of your dental records, photographs, x-rays or other supporting documentation in the processing of your request.
- The Scheme Manager reserves the right to recover the cost of a request admitted by the Scheme from any third party.
- Payment of the benefit is normally made direct to the patient unless directed otherwise.

YOUR DETAILS

Title: ________ Forename(s): ____________________ Surname: ______________________________ DOB: ______________

Address: ____

____ Postcode: ____________________

Home phone: ____________________ Daytime phone: ________________ Dental Plan Registration No: ________________

If you would like correspondence regarding your request sent by email please provide your email address: ________________

Email: ____

Have you made any previous claims under any dental insurance policy/scheme? ○ Yes ○ No

If yes, please give details and dates: ____

____

YOUR REGISTERED DENTIST DETAILS

Title: ________ Forename(s): ____________________ Surname: ______________________________

Practice Name: ____

Address: ____

____ Postcode: ____________________

Practice phone: ______________________________ E-mail: ______________________________

YOUR TREATING DENTIST/CONSULTANT DETAILS (if different from above)

If you are a registered DPAS dentist, please insert the practice reference number:

Title: ________ Forename(s): ____________________ Surname: ______________________________

Practice Name: ____

Address: ____

____ Postcode: ____________________

Practice phone: ______________________________ E-mail: ______________________________

Oral cancer

TREATMENT AND DIAGNOSIS DETAILS

Name of consultant: ______________________________

Name and Address of hospital: ______________________________

______________________________ Postcode: __________

What date did you first consult your dentist/doctor? ______________________________

By whom was the oral cancer first diagnosed? ______________________________

Is this a recurring mouth cancer? ○ Yes ○ No

If yes, date first diagnosed: ______________________________

Is any treatment being done by a maxillo/dental surgeon? ○ Yes ○ No

If yes, please give the name of the consultant: ______________________________

CONSENT TO OBTAIN A MEDICAL REPORT

Before we can apply for a medical report from your doctor and/or specialist, you must give your consent. Before giving your consent, you should be aware of your rights under the Access to Medical Reports Act 1988, which are summarised as follows:

Access to Medical Reports Act 1988

1. You may withhold your consent
2. You may see the report before it is sent to us within 21 days from the date of the report
3. You may ask to see the report for up to six months after the report is completed
4. You may ask the doctor/consultant to amend any part of the report, which you consider to be incorrect or misleading. If the doctor does not agree with your request you may attach your comments to the report.

The name of my G.P. is: ______________________________

The practising address of my G.P. is: ______________________________

______________________________ Postcode: __________

NB: The doctor/consultant may withhold all or part of the report from you if he/she considers that you may be physically or mentally harmed by it.

Hospital cash

BENEFIT DETAILS

Date of admission to hospital: ______________________ Time of admission to hospital: ______________________

Date of discharge from hospital: ______________________ Time of discharge from hospital: ______________________

Please provide proof of admission with this form e.g. copy of hospital admission/discharge letter.

Name and address of hospital: ____

____ Postcode: ______________________

Name of maxillo/dental surgeon under whose care you were admitted: ______________________

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Reason for admission to hospital: ____

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What treatment or advice was given? ____

____

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CONSULTANT'S DECLARATION

Are you the patients registered dentist? ◯ Yes ◯ No

I certify that the details of treatment (or where relevant, admission to hospital) given above are correct.

Signature: ____

Name (please print): ______________________________ Date: ______________________

If you are requesting assistance for hospital cash and are unable to obtain the consultant's signature, your dentist may be willing to sign this certificate.

Payment information

Method of payment:

◯ By BACS - payment will be made to the account from which your monthly payment for your dental plan is collected. If payment is to be paid to another account please enter details.

Account Name: ______________________________

Account Number: ______________________________

Sort Code: ______________________________

Patient declaration

I hereby consent for the Scheme Manager of the Worldwide Dental Emergency Assistance Scheme to:

- be provided with full access to my dental records and give authority for a full report to be supplied to them
- contact a medical practitioner/consultant to obtain information required for the processing of this request
- contact and share information with other scheme/insurance providers in relation to this request
- reclaim any benefits paid in error.

I understand that the information supplied will be used for underwriting and fraud prevention purposes, which may include the Worldwide Dental Emergency Assistance Scheme passing such details to agents or other scheme providers/insurers.
I hereby declare that these particulars are true to the best of my knowledge.

PATIENT MUST COMLETE AND SIGN THE APPROPRIATE DECLARATION BELOW:

ORAL CANCER

If patient is under 18 years then the declaration must be completed by the parent/guardian.

Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my request:

I hereby consent to the Scheme Manager seeking medical information from any doctor who at any time has attended to me concerning conditions that affect my physical or mental health. ○

I do wish to see the report before it is sent to the Scheme Manager ○

I do not wish to see the report before it is sent to the Scheme Manager ○

I authorise such doctor to disclose such information to the Scheme Manager ○

I agree that a copy of this consent shall have the validity of the original ○

Signature: ______________________ ○ Parent ○ Guardian

Name: ______________________ **Date:** ______________

HOSPITAL CASH

If patient is under 18 years then the declaration must be completed by the parent/guardian.

Signature: ______________________ ○ Parent ○ Guardian

Name: ______________________ **Date:** ______________

THE SCHEME MANAGER, CAMBRIAN WORKS, GOBOWEN ROAD, OSWESTRY, SHROPSHIRE SY11 1HS

Telephone: 0300 303 5065 **Email:** assistance@wdeas.co.uk
General enquiries relating to your dental plan: 01747 870910

Registered address:
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Cambrian Works, Gobowen Road, Oswestry
Shrewsbury, Shropshire SY11 1HS

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