T: Assistance Team 0300 303 5061

Cambrian Works, Gobowen Road, Oswestry SY11 1HS E: assistance@wdeas.co.uk



REQUEST FOR ASSISTANCE

Dental Trauma (Injury or Accident)

PATIENT'S DETAILS	PATI	EN1	ʹʹʹʹ	DETA	ILS
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To be completed in BLOCK CAPITALS.

Address:	Daytime telephone:
	Mobile phone:
Postcode:	Dental Plan reference number: (if known)
*Email address:	
*The email address supplied will be used to correspond with you.	
It is important that your request for assistance, where possible To obtain pre-authorisation, please contact the Assistance Teathe Dental Helpline on 0800 525631.	
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.	 You must at your expense, provide any reports, certificates, information and evidence that is relevant to support your request.
The admission of a request by the Worldwide Dental Emergency Assistance Scheme is at the sole and absolute discretion of the Scheme Manager.	 We may request copies of your dental records, photographs, x-rays or other supporting documentation in the processing of your request.
If admitted, your request will be considered by the Scheme Manager, against the schedule set out on page 4, which provides a guide to the level of Benefits to which you may be eligible. You will need to meet any other costs charged by the treating dentist.	 If a request for treatment abroad is admitted we will pay benefits in Pounds Sterling using FX Converter at www.oanda.com. The exchange rate will be calculated at the rate in force on the date of the payment unless evidence of Sterling conversion value is
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 sent to the Assistance Team within 60 days of the trauma or emergency incident, together with an itemised receipt or invoice from the treating dentist.	 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 dentist providing the treatment, but can be made to you if you have directly incurred costs.
CONSENT AND DECLARATION	
I hereby consent for the Scheme Manager of the Worldwide Dental • be provided with full access to my dental records and give author • contact a medical practitioner/consultant to obtain information rec • contact and share information with other scheme/insurance provi • reclaim any benefits paid in error.	rity for a full report to be supplied to them quired for the processing of this request
I understand that the information supplied will be used for underwrit prevention purposes, which may include the Worldwide Dental Eme passing such details to agents of other scheme providers/insurers. these particulars are true to the best of my knowledge.	ergency Assistance Scheme Office use only
Patient's signature:	
Date:	

SECTION A - TO BE COMPLETED AND SIGNED BY THE PATIENT

or drugs at the time of the incident? YES N If YES, please confirm the following: The amount of alcohol/drugs consumed in the period leading up to the incident: The type of alcohol/drugs consumed in the period leading up to the incident: The type of alcohol/drugs consumed in the period leading up to the incident: Over what period of time this took place: Did this influence the events which led to emergency treatment being required? YES N Do you have cover under an insurance policy/scheme? YES N If YES, please give the name of your insurance/scheme provide
The amount of alcohol/drugs consumed in the period leading up to the incident: The location of where the incident took place: The type of alcohol/drugs consumed in the period leading up to the incident: The type of alcohol/drugs consumed in the period leading up to the incident: Over what period of time this took place: Did this influence the events which led to emergency treatment being required? Do you have cover under an insurance policy/scheme? OYES N
The location of where the incident took place: The type of alcohol/drugs consumed in the period leading up to the incident: Please explain fully how the incident occurred: Over what period of time this took place: Did this influence the events which led to emergency treatment being required? YES ON Do you have cover under an insurance policy/scheme? YES N
the incident: Please explain fully how the incident occurred: Over what period of time this took place: Did this influence the events which led to emergency treatment being required? YES No. Do you have cover under an insurance policy/scheme? YES No.
Over what period of time this took place: Did this influence the events which led to emergency treatment being required? YES No Do you have cover under an insurance policy/scheme? YES No
Did this influence the events which led to emergency treatment being required? YES No Do you have cover under an insurance policy/scheme? YES No
to emergency treatment being required? YES No
Do you have cover under an insurance policy/scheme? YES N
If YES, please give the name of your insurance/scheme provide
Please describe the precise nature of the injury: Policy/scheme type:
Tolicy/scriente type.
Policy reference number:
SETTLEMENT
Please confirm who is to be reimbursed: Patient: Payment will be made directly to the account from which your dental plan payments are requested
Registered dentist/Practice Plan treating dentist: Payment will be made directly to the bank account held on our records
type of injury before? Non-Practice Plan treating dentist: If the treating dentist is not a Practice Plan provider please complete the accound details section below
Other (please state name and reason for alternative payee
Alternative account details:
Account holder's name:
Name and address of witness (if relevant):
Name: Name of bank:
Address: Sort code:
Account number:
Postcode:

SECTION B - TO BE COMPLETED BY THE REGISTERED/TREATING DENTIST

TREATING DENTIST'S DETAILS	Please confirm the remedial work to be carried out on each tooth
Name:	(If more space is required to complete a treatment plan, please continue on a separate piece of paper.)
Practice name and address:	
Postcode:	
Email:	
Telephone number:	
REGISTERED DENTIST'S DETAILS	Are there any factors which might contribute to the injury or may delay recovery? YES NO
Name:	If YES, please give details:
Practice name:	
Email:	
TRAUMA AND PROPOSED TREATMENT	Number of visits required to provide the treatment:
Please indicate which teeth have been damaged in the incident:	Estimated timescale in months:
1	PLEASE NOTE WE WILL NOT PAY BENEFIT FOR:
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8	1. Treatment where the dental injury is:a) caused by foodstuff (including any foreign body in
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8	food or drink)
Please can you confirm the damage sustained to each tooth:	 a minor tooth fracture which only involves damage to enamel in incisor teeth
	c) caused by normal wear and teard) any previously prescribed, diagnosed or planned
	treatment at the time of the dental trauma.
	2. Loss of or damage to dentures unless they are being worn at the time of the trauma.
	Please refer to the Scheme Handbook for full details of all limitations and exclusions.
	If a referral is required for treatment, please provide the clinician's details:
Please indicate the condition of the teeth prior to the trauma	Name:
taking place. For example: Were they virgin teeth? Were they previously filled?	Address:
Were they implants? Were they part of a bridge?	
	Postcode:
	Email:
	Telephone number:
	Please specify overleaf which clinician will be undertaking which

elements of the treatment plan.

TREATMENT PLAN

Please indicate in the table below the full cost of the treatment. Please note that incomplete treatment plans may result in a delay in authorisation to you and the patient. This treatment plan will be provided to the patient upon approval.

Please note, where the patient is entitled to receive discount on treatments, ensure the correct discounted amount is entered in the Dentist Charge column.

Treatment	Quantity	Tooth Notation	Dentist Charge	Office Use Only	Dentist initials
Examination	Per Incident				
X-rays	Per Incident				
Non-Surgical Extraction	Per Tooth				
Surgical Extraction	Per Tooth				
Filling - Small (build up only)	1 Surface				
Filling - Medium (build up only)	2 Surfaces				
Filling - Large (build up only)	3 + Surfaces				
Root Canal Therapy - Molar (to incl sealing canal)	Per Tooth				
Root Canal Therapy - Canine/Incisor (to incl sealing canal)	Per Tooth				
Root Canal Therapy - Pre-Molar (to incl sealing canal)	Per Tooth				
All Ceramic Crown*	Per Tooth				
Porcelain Bonded Crown*	Per Tooth				
Full Precious Metal Crown*	Per Tooth				
Porcelain Jacket Crown*	Per Tooth				
Dentine Bonded Crown (incl core /post)	Per Tooth				
Laboratory Made Post and Core	Per Tooth				
Post and Core (dentine)	Per Tooth				
Adhesive Bridge*	Per Pontic				
Adhesive Bridge*	Per Retainer				
Porcelain Bonded or Precious Metal Bridgework (Pontic)*	Per Pontic				
Porcelain Bonded or Precious Metal Bridgework (Retainer)*	Per Retainer				
Bridgework all metal*	Per Pontic				
Bridgework all metal*	Per Retainer				
Permanent Full Acrylic Denture	Per Denture				
Permanent Partial Acrylic Denture	Per Denture				
Permanent Cobalt/Chrome Denture	Per Denture				
Porcelain Veneer*	Per Tooth				
Temporary Denture (Following Tooth Loss)	Per Denture				
Temporary Bridge (Following Tooth Loss)	Per Unit				
Implants - Single Tooth*	Per Unit				
Addition to a Denture	Per Tooth				
Re-cement Bridge	Per Bridge				
Re-cement Crown/Veneer (re-cement only)	Per Tooth				
Other Necessary Treatment - Please list (including emergency attention where required)	Per Incident				
		TOTAL			

^{*}Treatment includes the fixture of prostheses (including all laboratory costs) and all surgery including second stage surgery

Fees for prosthetic work are inclusive of laboratory fees and any temporary covering. Prosthetic work includes crowns, veneers, implants, inlays, onlays, and all types of bridges and dentures, either full or partial.

Please note that you may only be reimbursed up to the individual maximum limits for the treatments and to the benefit limit (£10,000) as shown on your Benefit Schedule. You will need to meet any other costs charged.

Please note the time limits applicable to all requests for assistance:

For adults, treatment must be completed within two years of the date of the dental trauma.

For children, treatment of a dental injury must be completed within five years of the date of the dental trauma, or when the child turns 18, whichever is the later.

DECLARATION

I hereby declare that the information provided is accurate to the best of my knowledge and costs and quantities detailed in the Treatment Plan reflect any discounts related to the patient's Dental Plan.

Dentist's signature:	