T: Assistance Team 0300 303 5061
Cambrian Works, Gobowen Road, Oswestry SY11 1HS
E: assistance@wdeas.co.uk

Practiceplan

REQUEST FOR ASSISTANCE

Hospitalisation, Permanent Facial Disfigurement, and Oral Cancer

PATIENT'S DETAILS

To be completed in BLOCK CAPITALS.

Name:..... Date of birth: .....

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, has been pre-authorised prior to submission. To obtain pre-authorisation, please contact the Assistance Team on 0300 303 5061 or outside of office hours call the 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.

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 level of Benefits to which you may be eligible.

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 incident or diagnosis.
- 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 you.

CONSENT AND 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 of other scheme providers/insurers. I hereby declare that these particulars are true to the best of my knowledge.

Patient's signature: .....

Date: .....

Office use only

SECTION A - TO BE COMPLETED AND SIGNED BY THE PATIENT

PERMANENT FACIAL DISFIGUREMENT

(Only for requests directly relating to dental trauma)

Did the accident cause facial scarring to part of the neck, face or head that is normally exposed to view, which is expected to last for at least 12 months and is without prospect of recovery?

◯ YES ◯ NO

Please provide clear photographic evidence of the scar at the time of the event, and after 12 months has elapsed.

Photographs enclosed. ◯ YES ◯ *NO

Please provide measurements in centimetres: .....

HOSPITALISATION

(Only for requests directly relating to dental trauma)

Date of admission: .....

Date of discharge: .....

Number of days in hospital: .....

Payment is for each full 24 hours but excludes the first 24 hours.

Copy of discharge form enclosed. ◯ YES ◯ *NO

ORAL CANCER

(Only for requests where oral cancer is diagnosed as the primary site and is non-recurring either at the same site or in a different location in the oral cavity).

The location of the primary site of the tumour: .....

.....

Date of diagnosis: .....

Diagnosing consultant details:

Name: .....

Address: .....

.....

..... Postcode .....

Please ensure you enclose a copy of the letter from a medical consultant confirming the date of diagnosis.

Copy of consultant's letter enclosed ◯ YES ◯ *NO

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

◯ **Other** (please state name and reason for alternative payee).

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Alternative account details:

Account holder's name: .....

Name of bank: .....

Account number: ..... Sort code: .....

If NO, please note we will be unable to process this element of your request until received.

SECTION B - TO BE COMPLETED BY THE REGISTERED DENTIST

REGISTERED DENTIST'S DETAILS

Name: .....

Practice name and address: .....

.....

..... Postcode: .....

Email: .....

Telephone number: .....

DECLARATION

I hereby declare that the information provided is accurate to the best of my knowledge.

Dentist's signature: .....

Date: .....