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

Practiceplan

REQUEST FOR ASSISTANCE

Emergency Temporary Treatment Costs and Callout Fees

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 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.

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.
- 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.
- 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 submitted with 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 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 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

EMERGENCY APPOINTMENT DETAILS

*Total amount charged: £ .....

**Please provide a full breakdown of charges on Page 4*

Date of appointment: .....

Exact time of appointment: .....

◯ AM ◯ PM

Please describe the symptoms and reason for your dental emergency:

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Was the emergency as a result of an accident? € ◯ YES * ◯ NO

* If your request also involves treatment and continuing dental work as a result of a dental trauma, you should also complete the Dental Trauma Request for Assistance Form and return BOTH forms to the Scheme Manager.

Were you under the influence of alcohol or drugs at the time of the incident? ◯ YES ◯ NO

If YES, please confirm the following:

The amount of alcohol/drugs consumed in the period leading up to the incident:

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The type of alcohol/drugs consumed in the period leading up to the incident:

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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/scheme policy? ◯ YES ◯ NO

If YES, please give the name of your insurance/scheme provider:

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Policy/scheme type: .....

Policy Reference number: .....

TREATMENT RECEIVED OUTSIDE THE UK

What date did you leave the UK?:

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What date did you return?:

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Please confirm the currency used to complete the payment:

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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

◯ **Non-Practice Plan treating dentist:** If the treating dentist is not a Practice Plan provider please complete the account details section below

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

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Alternative account details:

Account holder's name: .....

Name of bank: .....

Sort code: .....

Account number: .....

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

TREATING DENTIST'S DETAILS

Name: .....

Practice name and address: .....

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Postcode: .....

Email: .....

Telephone number: .....

REGISTERED DENTIST'S DETAILS

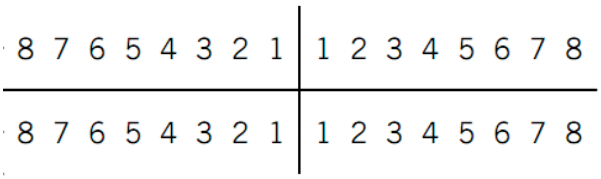
Name: .....

Practice name: .....

Email: .....

EMERGENCY TEMPORARY TREATMENT

Please indicate which teeth required emergency treatment:



Please can you confirm the reason why treatment was necessary for each tooth:

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Please confirm the temporary treatment carried out on each tooth.

(If more space is required, please continue on a separate piece of paper.)

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PLEASE NOTE WE WILL NOT PAY BENEFIT FOR:

1. A Request for Assistance for any incident which occurs when the patient is residing outside the United Kingdom for more than 90 consecutive days.
2. Treatment received during normal working hours (8.00 am to 6.00 pm, Monday to Friday), provided by any of the following:
   - The registered dentist
   - Another dentist at the same practice
   - A dental practice within a 15 mile radius of the patient's registered practice.
3. Permanent treatment. Should permanent treatment be necessary, cover will be paid at the equivalent temporary limit.
4. Any subsequent treatment required after the initial appointment is specifically excluded.

BREAKDOWN OF CALLOUT FEE AND EMERGENCY TEMPORARY TREATMENT

	Units	Tooth Notation	Limit (£)	Dentist Charge	Office Use Only
Emergency Callout Fee					
Weekdays - 6am-8am, 6pm-10pm	Per Incident		135.00		
Weekdays & weekends - 10pm-6am	Per Incident		200.00		
Weekends & bank holidays - 6am-10pm	Per Incident		180.00		
Emergency Temporary Treatment Costs (Please note treatment is subject to a benefit cap of £460.00)					
Examination	Per Incident		47.00		
X-rays	Per Incident		31.00		
Treatment to stop haemorrhage	Per Incident		50.00		
Tooth extraction (max two teeth)	Per Tooth		80.00		
Root extirpation - 1 canal	Per Tooth		100.00		
Root extirpation - 2 canals	Per Tooth		105.00		
Root extirpation - 3+ canals	Per Tooth		140.00		
Treatment of infection	Per Incident		33.00		
Investigation - 1st tooth	Per Tooth		43.00		
Investigation - additional teeth	Per Tooth		24.00		
Resecure crown or inlay	Per Tooth		43.00		
Resecure bridge	Per Bridge		54.00		
Temporary bridge	Per Bridge		155.00		
Temporary crown	Per Tooth		67.00		
Temporary post and core	Per Tooth		75.00		
Repair/adjust orthodontic appliance	Per Appliance		58.00		
Repair of denture	Per Denture		52.00		
Adjust denture	Per Denture		32.00		
Remove sutures	Per Incident		30.00		
Other emergency temporary treatment (please list)	Per Incident		73.00		
Emergency – International (Inclusive of callout & treatment)	Per Incident		460.00		
		TOTAL			

Please note that you may only be reimbursed up to individual maximum limits for the treatments (as shown on the Benefit Schedule) subject to an overall benefit limit of £460 and an annual limit of £920.

You will need to meet any other costs charged.

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: .....

Date: .....