

**T: Assistance Team 0300 303 5061**

Cambrian Works, Gobowen Road, Oswestry SY11 1HS

E: assistance@wdeas.co.uk

**Practiceplan****REQUEST FOR ASSISTANCE****Dental Trauma (Injury or Accident)****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-authorized prior to submission. To obtain pre-authorization, 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](http://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

## INCIDENT DETAILS

Date of incident: .....

Time of incident: .....

The location of where the incident took place:

.....

.....

Please explain fully how the incident occurred:

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Please describe the precise nature of the injury:

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Have you ever suffered a similar type of injury before?  YES  NO

If YES, please give details:

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Name and address of witness (if relevant):

Name: .....

Address: .....

.....

.....

Postcode: .....

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:

.....

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  NO

Do you have cover under an insurance policy/scheme?  YES  NO

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

.....

Policy/scheme 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

**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: .....

.....

.....

Postcode: .....

Email: .....

Telephone number: .....

## REGISTERED DENTIST'S DETAILS

Name: .....

Practice name: .....

.....

Email: .....

## TRAUMA AND PROPOSED TREATMENT

Please indicate which teeth have been damaged in the incident:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Please can you confirm the damage sustained to each tooth:

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Please indicate the condition of the teeth prior to the trauma taking place.

*For example: Were they virgin teeth? Were they previously filled? Were they implants? Were they part of a bridge?*

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Please confirm the remedial work to be carried out on each tooth.  
(If more space is required to complete a treatment plan, please continue on a separate piece of paper.)

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Are there any factors which might contribute to the injury or may delay recovery?  YES  NO

If YES, please give details:

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Number of visits required to provide the treatment: .....

Estimated timescale in months: .....

### PLEASE NOTE WE WILL NOT PAY BENEFIT FOR:

1. Treatment where the dental injury is:
  - a) caused by foodstuff (including any foreign body in food or drink)
  - b) a minor tooth fracture which only involves damage to enamel in incisor teeth
  - c) caused by normal wear and tear
  - d) 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:

Name: .....

Address: .....

.....

.....

Postcode: .....

Email: .....

Telephone number: .....

Please specify overleaf which clinician will be undertaking which elements of the treatment plan.

