T: Assistance Team 03300 532 061
Cambrian Works, Gobowen Road, Oswestry SY11 1HS
E: assistance@wdeas.co.uk

Worldwide
Dental Emergency Assistance Scheme

Request for Assistance

Dental Trauma (Injury or Accident)

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 03300 532 061 or outside of office hours call the Dental Helpline on 0800 525631.

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.

You will need to meet any other costs charged by the treating dentist.

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 scheme.wdeas.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 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.

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.*

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 reviewing performance of the Scheme, 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: .....

Date treatment started (first appointment): .....

Date contacted dentist regarding the incident: .....

What damage did you notice within 7 days of the incident?

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Please provide reason for delay of this request, if more than 60 days from the date of the incident:

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The location of where the incident took place:

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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: .....

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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:

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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/DPAS treating dentist:** Payment will be made directly to the bank account held on our records

◯ **Non-Practice Plan/DPAS treating dentist:** If the treating dentist is not a Practice Plan/DPAS 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: .....

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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What treatment has been given so far?

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Please indicate the condition of the teeth with details of any pre-existing conditions, prior to the trauma.

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: .....

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..... 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	Indicate if emergency treatment
Examination	Per Incident				
X-rays	Upto 2 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.

CHECKLIST : BEFORE YOU SUBMIT THIS FORM, PLEASE CHECK

- Has it been signed, by dentist and patient where applicable?
- Has a treatment plan, itemised invoice, receipt or statement of account been included?
- Has every section been completed?

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: .....