Emergency Treatment Request for Assistance Form

Highland Dental Plan Ltd

Emergency only ☐

Hospitalisation ☐

Dental injury ☐

Request for Assistance No:

Plan Type: *Full care* ☐ *Maintenance* ☐ *Children's* ☐

Patient Registration number: | | | | | | |

Please ensure all relevant questions are answered and all appropriate sections and boxes are completed fully. Failure to do so may delay processing the Request for Assistance.

PATIENT DETAILS

Title | Forename (s) | Surname

Address

Date of Birth

DETAILS OF PATIENT'S REGISTERED DENTIST

Dentist Name | Dentist ID No.

TO BE COMPLETED BY TREATING DENTIST

Name of Dentist | Dentist ID No. ***(if HDP Dentist)***

Address

Practice Stamp

I request assistance for the treatment carried out overleaf (please attach detailed account of treatment)

Treating Dentist's Signature | *Date*

Total £ : | Patient Paid £ : | Total Assistance Requested £ :

Pay patient ☐ | Pay Dentist ☐ | ***Pay by direct credit into account details held by HDP*** ☐

Pay by cheque ☐ | ***Cheque made payable to (BLOCK CAPITALS)***

OUT OF HOURS TREATMENT - REQUEST FOR ASSISTANCE

Emergency took place 'out of hours' on (Date and Time)

Day	***Date***	***Time***	***am/pm***

Description of Emergency and the Temporary Emergency Treatment carried out

EMERGENCY TREATMENT - REQUEST FOR ASSISTANCE

PLEASE REFER TO SECTION 1 OF THE DEAS INFORMATION BOOKLET FOR LIMITS PAYABLE

If the treating dentist is the patient's registered dentist or a dentist deputising for the patient's registered dentist assistance can only be requested for items 20 & 21.

TREATMENT TYPE			AMOUNT REQUESTED
1	Examination and report to include all necessary smoothing and polishing of teeth and treatment of sensitivity		£
2	Radiographic examination		£
3	Tooth extraction up to 2 teeth		£
4	Root extirpation, including dressing and any associated treatment of acute infection	1 canal	£
		2 canals	£
		3 or more canals	£
5	Treatment of acute infection to include incising of abscesses/treatment of infected sockets/ any prescribed medication		£
6	Investigation and dressing - First tooth		£
7	Investigation and dressing - Each additional tooth		£
8	Recement crown, inlay or veneer		£
9	Recement bridge		£
10	Construction and fitting of temporary crown		£
11	Construction and fitting of temporary bridge		£
12	Provision of temporary post and core		£
13	Temporary denture after tooth loss		£
14	Arrest abnormal haemorrhage including aftercare and associated suture removal		£
15	Removal of sutures placed by another dentist		£
16	Repair/adjustment of orthodontic appliance		£
17	Adjustment to denture		£
18	Repair of denture to include re-fixing of teeth and gum and repair of clasp		£
19	Any other Emergency Temporary Treatment not otherwise specified		£

		AMOUNT REQUESTED
20	Evening weekend and Bank Holiday call-out fees where the dentist returns to the practice to re-open it to provide emergency treatment when the surgery would not normally be open	£
21	From 6pm on 24th December until 12:01am on 27th December and again from 6pm on 31st December until 12:01am on 3rd January any call-out fees where the dentist returns to the practice to re-open it to provide emergency treatment when the surgery would not normally be open	£

HOSPITALISATION - REQUEST FOR ASSISTANCE (Please give details)

From	**/**	**/**	***am/pm***	***to***	**/**	**/**	***am/pm***

Name and address of hospital—Please enclose the hospital discharge form

PATIENT DECLARATION

I confirm I am registered with Highland Dental Plan Ltd. I understand the treatment as detailed has been carried out and request assistance for the fees paid by me (if any).

I declare that the above statements are true and correct to the best of my knowledge and belief. I have not withheld from Highland Dental Plan Ltd any information within my knowledge connected with this Request for Assistance.

I accept that any false declaration or statement made by me means that I will not be entitled to receive any benefit in respect of this Request for Assistance and may render me liable to prosecution.

I agree to provide Highland Dental Plan Ltd with any further information or documentation as may be reasonably required. I understand that Highland Dental Plan Ltd does not admit liability by the issue of this form.

I understand that Highland Dental Plan Ltd reserves the right to appoint an examiner or make any other enquiries it considers appropriate before agreeing to any payments in connection with this request for assistance.

Signature of Patient	***Print Name***	***Date***

IMPORTANT INFORMATION

Patients requesting assistance for Emergency Treatment should ensure all original receipts are enclosed (copies will NOT be accepted).

If your Request for Assistance is for Emergency Treatment outside of the United Kingdom please provide us with proof of travel dates to enable us to process your request.

This form should be submitted within 90 days of completion of treatment.

Completed form to be returned to:

Highland Dental Plan Ltd
River House
Young Street
Inverness
IV3 5BL

Request for Assistance Helpline Number:

01463 712585

THE DEAS INFORMATION BOOKLET IS AVAILABLE TO VIEW ON OUR WEBSITE

www.highlanddentalplan.co.uk

For office use only

Signature of Administrator authorising Request for Assistance	Request settled by direct credit	
	Request settled by cheque	
Signature of Administrator settling Request	Date request settled	

HIGHLAND DENTAL PLAN LTD
RIVERHOUSE
YOUNG STREET
INVERNESS
IV3 5BL