|  |  |
| --- | --- |
| **Application for Approval to Provide Treatment Not Covered by the Standard Fee Schedule** |  |
|  |  |
| Payee number |  | Agreement number |  | Please tick appropriate box () |
|   |   |   |   |   |   |  |   |   |   |   |   |   |  |  | OHSA [ ] H/Caries [ ] SDS [ ]  |
| Dental health practitioner’s name |  | DCNZ number |
|       |  |   |   |   |   |   |   |  |
| Practice address |  | Patient’s name |
|       |  |       |
|  | Date of birth |  | NHI number (mandatory) |
|  |   |   |   |   |   |   |   |   |  |   |   |   |   |   |   |   |
| Patient’s condition and dentist’s comments. |
|       |

Note: Radiographs should be provided (or may be requested) in support where appropriate.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |   |   |   |   |   |   |   |   |
| Dentist’s signature |  | Date |

Approval is sought to provide treatment as set out below for the above named patient.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Code** | **Tooth number/s** | **Qty** | **Fee** |  | **Code** | **Tooth number/s** | **Qty** | **Fee** |  | **Code** | **Tooth number/s** | **Qty** | **Fee** |
| MSO1 |       |       |       |  | PDT1 |       |       |       |  | DEN3 |       |       |       |
| MSO2 |       |       |       |  | PST1 |       |       |       |  | DEN4 |       |       |       |
| CRN2 |       |       |       |  | PST2 |       |       |       |  | DEN5 |       |       |       |
| CRN3 |       |       |       |  | VEN1 |       |       |       |  | DEN6 |       |       |       |
| CRN4 |       |       |       |  | VEN2 |       |       |       |  | DEN7 |       |       |       |
| CRN5 |       |       |       |  | DEN1 |       |       |       |  | APX1 |       |       |       |
|  |  |  |  |  | DEN2 |       |       |       |  | ABMT |       |       |       |
|  |  |  |  |  |  |  |  |  |  | SPLT |       |       |       |

For authorisation under high caries treatment please note codes below in addition to any of the above.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Code** | **Tooth number/s** | **Qty** | **Fee** |  | **Code** | **Tooth number/s** | **Qty** | **Fee** |  | **Code** | **Tooth number/s** | **Qty** | **Fee** |
| CON5 |       |       |       |  | FIL6 |       |       |       |  | RCT4 |       |       |       |
| FIS1 |       |       |       |  | RAD1 |       |       |       |  | RCT5 |       |       |       |
| FIL1 |       |       |       |  | RAD2 |       |       |       |  | EXT1 |       |       |       |
| FIL2 |       |       |       |  | RAD3 |       |       |       |  | EXT2 |       |       |       |
| FIL3 |       |       |       |  | RCT1 |       |       |       |  | CRN1 |       |       |       |
| FIL4 |       |       |       |  | RCT2 |       |       |       |  | EMD1 |       |       |       |
| FIL5 |       |       |       |  | RCT3 |       |       |       |  | RCM1 |       |       |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Approved [ ]  | Not approved [ ]  | Total proposed fee (GST exclusive) ($) |       |
|  |
| Approval number |   |   |   |   |   |   |   |   |   |   |   |
| Approving dental officer’s comments |
|       |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |       |  |   |   |   |   |   |   |   |   |
| Dental officer’s signature |  | District Area |  | Date |

Please send to your District’s approving dental officer (ADO) for approval. Attach the 'original' approved form to the claim and send for processing to: Te Whatu Ora, PO Box 1026, Wellington, New Zealand. Telephone 0800 855 066. HP 5958
 June 2023