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| **Oral Health Services for Adolescents**  **Claim Summary Form** | |
| claim number | [Type here] |
| Te Whatu Ora use only | |
| Claim reference (unique per claim, alpha-numeric characters only) | |
| [Type here] | |
| Payee number   |  | | --- | | [#] | | |
| Agreement number | |
| |  | | --- | | [#] |   Agreement holder’s name | |
| [Type here] | |

Name of dental health practitioner (who treated the patients on the attached Individual Treatment Report/s)

|  |
| --- |
| [Type here] |

DCNZ number (of health practitioner who treated the patients on the attached Individual Treatment Report/s)

|  |
| --- |
| [#] |

|  |  |  |  |
| --- | --- | --- | --- |
| Number of patients in this claim | | | [#] |
|  | | |  |
| Value of treatment reports (GST exclusive) ($) | | [#] | |
|  | |  |
| GST ($) | | [#] | |
|  | |  |
| Total (GST inclusive) ($) | | [#] | |

Te Whatu Ora only

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| Total paid ($) | [#] |

**Certification**

I certify that the above and attached particulars are true and correct and comply with the terms and conditions of my agreement.

|  |  |  |
| --- | --- | --- |
| [Type here] |  | [DD/MM/YYYY] |

Agreement holder’s signature Date

Please complete and email to [cdaclaims@health.govt.nz](mailto:cdaclaims@health.govt.nz). Telephone 0800 855 066 HP 5952 Jun 2023