**Codes and Descriptions - Special Dental Services**

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| **Code** | **Description** |  | **Code** | **Description** | |
| APX1 | Apexification/root filling teeth with an open apex |  | PDT1 | Treatment of Periodontal Disease | |
|  | PST1 | Cast post and core | |
| CON3 | Initial oral consultation for school dental clinic patients referred for Special Dental Services or for the school dental clinic patients or adolescents who are not able to access their regular oral health provider in an emergency during normal practice hours.   PLEASE NOTE: You cannot claim CON3 for you own patients. |  | PST2 | Preformed post (para, flexi, etc) and core | |
|  | RAD1 | Periapical radiograph | |
| RAD2 | Panoramic radiograph | |
| CON4 | Emergency consultation after hours (indicate time) |  | RAD3 | Occlusal radiograph | |
| CRN1 | Preformed metal crown |  | RCT1 | Root canal treatment and root filling in permanent anterior or premolar teeth (per canal) including all necessary radiographs performed during treatment and mandatory post-operative radiology for patient's record | |
| CRN3 | All Ceramic crown (partial or full coverage) |
| CRN4 | Gold crown (partial or full coverage) |
| CRN5 | Complex reconstruction in composite resin |
| DEN3 | Acrylic partial denture |  | RCT2 | Pulp removal and root filling in a deciduous tooth (maximum fee per deciduous tooth treated) | |
| DEN4 | Acrylic partial denture – each extra tooth |  | RCT3 | Pulpotomy in deciduous tooth | |
| DEN5 | Acrylic partial denture – each clasp |  | RCT4 | Pulpotomy in permanent tooth | |
| DEN6 | Denture full upper or lower |  | RCT5 | Root Canal treatment and root fillings in permanent molar teeth (per canal treated) including all necessary radiographs performed during treatment and a mandatory post-operative radiograph for the patient's record. | |
| DEN7 | Dentures upper and lower |
| EMD1 | Emergency dressing |  | RCM1 | Re-cement inlay or crown | |
| EXT1 | Extraction of a single permanent tooth or deciduous quadrant (excluding extractions for orthodontic purposes)  with local anaesthetic |  | SPLT | Bite splints | |
| VEN2 | Labial composite veneers | |
| EXT3 | Extraction of a single permanent tooth or deciduous quadrant (excluding extractions for orthodontic purposes)  with general anaesthetic |  |  |  | |
| FIL1 | One surface restoration in posterior teeth (including the anterior and posterior pit and all buccal, palatal and lingual fissure extensions of molars) |  |  |  | |
| FIL2 | Two surface (approximo‑occusal) restorations in posterior teeth |  |  |  | |
| FIL3 | Three surface (mesio‑occusal‑distal) restorations in posterior teeth |  |  |  | |
| FIL4 | Complex coronal reconstructions (including restoration of one or more cusps) |  |  |  | |
| FIL5 | Simple non-metallic restorations in anterior teeth |  |  |  | |
| FIL6 | More than one surface non-metallic restorations in anterior teeth |  |  |  | |
| MSO1 | Minor surgical operation or other time based procedures – 1st half hour |  |  |  | |
| MSO2 | Minor surgical operation or other time based procedures – each additional quarter hour |  |  |  | |
| PBW1 | Bitewing radiograph |  |  |  | |

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

HP 5959  
June 2023

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| **Special Dental Services Individual Treatment Report**  This form must be attached to a completed claim summary form (HP5957) | | | | | | |  |
| NHI number (mandatory) | | | | |  | Patient’s last name | |
|  | |  |  | |  |  | |
| Date of birth | ((DD/MM/YYYY) | | |  |  | Patient’s first name | |
|  | | |  |  |  |  | |
| Sex | | | | |  | Address of patient | |
| Male  Female  Other | | | | |  |  | |
| Name of school or oral health practitioner | | | | |  | Name of usualoral health practitioner | |
|  | | | | |  |  | |
| Town / city of school or oral health practitioner | | | | |  | Town / city of usual oral health practitioner | |
|  | | | | |  |  | |

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| **To be completed by agreement holder** |

The required treatment was (tick applicable box)

1. As referred: Referral letter attached (if referral letter is not attached, write referral number).

2. Emergency care for a child enrolled in the Community Oral Health Service (COHS). Give name of patient’s school or dental clinic and town/city (mandatory).

3. Treatment for a child enrolled in the COHS who was presented to you without referral by a COHS oral health therapist or dental therapist. Indicate dental clinic or school and town/city (mandatory).

4. Emergency care for a child enrolled for Oral Health Services for Adolescents with another provider. Indicate the name of usual provider and town/city (mandatory).

5. Emergency care for a preschool, primary, intermediate or adolescent school child who is enrolled with neither the COHS nor a private patient of a dentist.

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| **Date of treatment** (DD/MM/YYYY) | **Code** | **Comments** | **Quantity** | **Teeth** | **Value $** | **Te Whatu Ora only** |

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| **Standard services not requiring prior approval** | Community Oral Health Service referral number |  |

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| **Standard services requiring prior approval** | Approval number |  |

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|  |  |  |  |  |  |  |
|  | | | Total claimed (GST exclusive) | | $ | $ |

Please complete and email to [cdaclaims@health.govt.nz](mailto:cdaclaims@health.govt.nz)  Telephone 0800 855 066 HP 5959  
 June 2023