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| **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.

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

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

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| **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.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |  |  |  |

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