

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 (DD/MM/YY)

NHI number (mandatory)

Patient's condition and practitioner's comments.

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

Practitioner's signature

Date (DD/MM/YY)

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

Code	Tooth number/s	Qty	Fee
MSO1			
MSO2			
CRN2			
CRN3			
CRN4			
CRN5			

Code	Tooth number/s	Qty	Fee
PDT1			
PST1			
PST2			
VEN1			
VEN2			
DEN1			
DEN2			
RCT5			

Code	Tooth number/s	Qty	Fee
DEN3			
DEN4			
DEN5			
DEN6			
DEN7			
APX1			
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
CON5			
FIS1			
FIL1			
FIL3			
FIL4			
FIL5			

Code	Tooth number/s	Qty	Fee
FIL6			
RAD1			
RAD2			
RCT1			
RCT2			
RCT3			

Code	Tooth number/s	Qty	Fee
RCT4			
RCT5			
EXT1			
CRN1			
EMD1			
RCM1			

Total proposed fee (GST exclusive) (\$)

Approved

Not approved

Approval number

Approving dental officer's comments

Dental officer's signature

Local district Te Whatu Ora

Date (DD/MM/YY)