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| **High Caries Treatment Planning (Adolescents)****Treatment Report/Claim Summary Form** |
|  |  |  |  |  | Claim number | [#] |
|  |  |  |  |  | Te Whatu Ora use only |
| Claim reference number *(unique number per claim)* |  |  |  | Payee number | DCNZ numberof treating health practitioner |
| [#] |  | [Type here] | [#] |
| Agreement holder’s name |  |  |  | Agreement number |  |
| [Type here] |  | [#] |
| NHI number (mandatory) | Name of treating oral health practitioner |
| [#] |  | [Type here] |
| Patient’s last name |  |  |  | Patient’s first name |  |
| [Type here] |  | [Type here] |
| Date of birth |  |  |  | Sex |  |
| [DD/MM/YYYY] |  |  |  | Male [ ]  Female [ ]  Othe**r** [ ]  |
| School attended |  |  |  | School number | School EQI Code |
| [Type here] |  | [#] | [Type here] |
| Approval number |  |  |  |
| [#] |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of treatment** | **Code** | **Qty** | **Teeth** | **Value****$** | **Te Whatu Ora only** |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| [DD/MM/YYYY] | [Type here] | [#] | [Type here] | [#] |  |
| Total claimed (GST exclusive) ($) GST ($)Total claimed (GST inclusive) ($) | [#] |  |
| [#] |
| [#] |

**Certification**

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

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

Agreement holder’s signature Date

Please complete and email to cdaclaims@health.govt.nz. Telephone 0800 855 066 HP 5955 June 2023