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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 number  of 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 | | |  |  |  | | |
| [#] | | |  |  |  | | |

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| --- | --- | --- | --- | --- | --- |
| **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](mailto:cdaclaims@health.govt.nz). Telephone 0800 855 066 HP 5955 June 2023