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| --- |
| **Oral Health Services for Adolescents****Claim Summary Form** |
| claim number | [Type here] |
| Te Whatu Ora use only |
| Claim reference (unique per claim, alpha-numeric characters only) |
| [Type here] |
| Payee number

|  |
| --- |
| [#] |

 |
| Agreement number |
|

|  |
| --- |
| [#] |

Agreement holder’s name |
| [Type here] |

 Name of dental health practitioner (who treated the patients on the attached Individual Treatment Report/s)

|  |
| --- |
| [Type here] |

DCNZ number (of health practitioner who treated the patients on the attached Individual Treatment Report/s)

|  |
| --- |
| [#] |

|  |  |
| --- | --- |
| Number of patients in this claim  | [#] |
|  |  |
| Value of treatment reports (GST exclusive) ($) | [#] |
|  |  |
| GST ($) | [#] |
|  |  |
| Total (GST inclusive) ($) | [#] |

Te Whatu Ora only

|  |  |
| --- | --- |
| Total paid ($) | [#] |

**Certification**

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

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

Agreement holder’s signature Date

 Please complete and email to cdaclaims@health.govt.nz. Telephone 0800 855 066 HP 5952 Jun 2023