



# Dental Pre-authorisation Request Form

To be completed by Dental Service Provider



## Dentist or Dental Therapist Details

Referring Doctor	<input type="text"/>	Postal Address	<input type="text"/>
Practice Number	<input type="text"/>		<input type="text"/>
Therapist	<input type="text"/>		<input type="text"/>
Practice Number	<input type="text"/>		<input type="text"/> Code <input type="text"/>
Dentist / Therapist Tel (W)	<input type="text"/>		
Dentist / Therapist Cell	<input type="text"/>		
Dentist / Therapist Fax	<input type="text"/>		
Dentist / Therapist E-mail	<input type="text"/>		

## Patient Details

Title	<input type="text"/>	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Principal Member Surname	<input type="text"/>
First name	<input type="text"/>				Principal Member Initials	<input type="text"/>
Surname	<input type="text"/>				Medical Scheme Name	<input type="text"/>
Identity Number	<input type="text"/>				Medical Scheme Option	<input type="text"/>
Tel (W)	<input type="text"/>				Membership Number	<input type="text"/>
Tel (H)	<input type="text"/>				Dependant Code	<input type="text"/>
Cell	<input type="text"/>					
E-mail	<input type="text"/>					
Postal Address	<input type="text"/>					
	<input type="text"/>					
	<input type="text"/>					
Employer	<input type="text"/>					

## The following Benefits require pre-authorisation

- 5th or more Amalgam restorations per beneficiary per annum
- 5th or more Resin fillings (anterior only) per beneficiary per annum
- 5th or more non-surgical Extractions per beneficiary per annum
- 3rd or more bite wing X-rays (maximum 4) per beneficiary per annum
- Dentures and all Specialised Dentistry

## Essential Dentistry (Please specify relevant Procedure Codes / Teeth Numbers)

Procedure Codes	Teeth Numbers	Procedure Codes	Teeth Numbers	Procedure Codes	Teeth Numbers
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## Denture Application (Full Upper & Lower / Full Upper or Lower / Partial Denture)

Item	Procedure Codes	Co-payment
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

## Clinical Motivation for Additional Dental Benefits

Signature..... Date.....

## Pre-Authorisation Request Procedure

Please note that application forms are to be completed in full and submitted to the following fax numbers: 0866 738 106 or 0866 425 046. Should benefits be approved, a letter of authorisation will be faxed to the attending Dentist / Dental Therapist within three (3) working days of receipt of this form and approval of benefits.

<b>Enquiries contact:</b>	<b>Medicross</b>	<b>0860 10 11 51</b>
	<b>Prime Cure</b>	<b>0861 665 665</b>



You're in safe hands