Dentistry Pre-authorisation Request Form

To Be Completed By Member

Main Member First Name (s) :

Main Member Surname : | Membership No :

Cellphone No: | Home No. :

Email : | Work No. :

Patient's Names:

Medical Aid Option: | Date of Birth :

Dependant Code:

Patient Signature:

Date:

To Be Completed by Practice Accounts Department

Practice Name:

Dr's Name (s): | Dr 's Surname :

Practice Contact no. : | Dr's Practice No :

Practice Email:

Hospital Name: | Hospital Practice No :

Type of Procedure:

- ✔ Specialised Dentistry
- ✔ Dentistry done under General Anesthetic in Hospital
- ✔ Dentistry done under IV sedation in Rooms
- ✔ Dentistry done under IV sedation in Hospital

Clinical Motivation for the Procedure:

Nature of Procedure and Brief Clinical History:

CODES	DESCRIPTION	ICD 10 CODE	TOOTH NUMBER	FEE
LAB CODES	**LAB DESCRIPTION**			**FEE**
			TOTAL FEE	

Dental Procedures already performed and outcome:

Date of Procedure:

*Please Note: Radiographs may be requested for purpose of benefit allocation

Acknowledgement by Examinating Doctor

I certify that the particulars hereto are – to the best of my knowledge and belief – true and accurate, having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to.

Signature of Medical Practitioner

Date

Place QR code/barcode or Stamp