pps
FOR PROFESSIONALS
SINCE 1941

HEALTHCARE ADMINISTRATORS

DENTAL AUTHORISATION REQUEST FORM

E-mail completed form to dental@profmed.co.za

MEMBERS DETAILS

Membership number: _____

Member name and surname: _____

PATIENT DETAILS

Patient name and surname: _____

Patient dependant code: _____

PROCEDURE DETAILS

Date of procedure : _____

Practice name: _____

Practice number: _____

Practice contact information: _____

PROCEDURE DETAILS					
Procedure Codes	Amount	ICD-10 codes	Tooth Number/s	LAB Codes	LAB Amounts

Clear radiographs to be submited

FOR HOSPITAL ADMISSION:

Date of admission : _____

Hospital name: _____

Practice number: _____

FOR ORTHODONTICS:

A cephalometric tracing must be submitted

FOR PERIODONTAL TREATMENT:

A CPITN index and maintenance plan must be submitted