

PATHFINDER: APPLICATION FOR CROWN, BRIDGE, VENEER AND SERVICE FOR CHROME-COBALT DENTURES/ PLASTIC DENTURES

RETURN TO: SPECIALISED DENTISTRY PRIVATE BAG X128 CENTURION 0046. dentalpreauths@caretech.co.za.
ENQUIRIES: 0861 147 741

How to complete this form

- Please consult your regular doctor to complete the application form.
- Complete one form per patient. Additional forms are available by dialling 082 239 2865 from a 'tone-set' fax machine.

Section A – To be completed by the member

Patient particulars

| | | | |
|----------------|-----------------|---------------|-------|
| Surname | | Membership no | |
| First name | | Dependant | |
| Postal address | Title | Gender | M F |
| | Tel (home) code | | |
| | Tel (work) code | | |
| Area code | Date of birth | | |

Principal member particulars

| | | | | | |
|--------------|----|----------------|--|----------|--|
| Surname | | Title | | Initials | |
| ID number | | Option | | | |
| Tel (w) code | No | Cell phone no. | | | |
| Tel (h) code | No | Fax code/no. | | | |

Please indicate where the pre-authorisation should be sent to:

Please mark only ONE option:

- OPTION 1:** My dentist (provide details), or
- OPTION 2:** Myself (provide details – please take confidentiality into consideration when providing a fax number).

Details where pre-authorisation document should be faxed to:

| | | | |
|----------------|----------------|----------------|--|
| Dentist | | Dr practice no | |
| Contact person | Tel (Code) | | |
| Fax (Code) | e-mail address | | |

Patient declaration

- I understand and accept that personal clinical information will be made available to my medical scheme and their authorised agents in order to make informed recommendations regarding my teeth.
- I understand that the information will remain confidential at all times.
- I declare that the information supplied is correct.

Signature of patient
(If patient is older than 14 years)

Signature of principal member
(If patient is younger than 14 yrs old)

Date

Section B – To be completed by the dentist

Important information

- Please provide X-rays for crown and bridge work with the tooth numbers
- Please provide Pathfinder with the missing tooth numbers for this application.
- Please do not send any radiographs unless requested (only for chrome-cobalt service)
- Please provide Pathfinder with the proposed clinical codes, (missing) tooth numbers and cost

Patient particulars

| | | | |
|----------|--|-------------------|--------------|
| Surname | | Membership number | |
| Initials | | Title | Dependant no |

Treatment to be considered for dental authorisation

| Clinical codes | Tooth numbers | Cost |
|----------------|---------------|------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Proposed laboratory codes and costs (please specify individual codes rather than only stating 8099 and the total cost). In cases where the 'global fee structure' is intended, it must be indicated clearly. Should unregistered items/codes be intended, please specify the exact wording clearly in such a case:

Periodontal status

Motivation and additional information for application:

Treatment phases (should all the treatment not be completed during the same benefits year or the same service date):

Particulars of dental practitioner

| | | | |
|-----------------|--|----------------|-----------|
| Name of dentist | | | |
| Address | | | Area code |
| | | | |
| HPCSA number | | Tel (code) | |
| Practice number | | Fax (code) | |
| Date | | e-mail address | |
| Signature | | Qualification | |