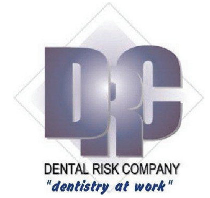
Authorisation form for basic dentistry



Please fax this form to 086 687 1285

PROVIDER DETAILS

Provider name: ______________________________

Practice number: ______________________________

Town: ______________________________

Date of application: ______________________________

Tel: ______________ Fax: ______________ Email: ______________

Dental Risk Company Network provider ☐ Y ☐ N

PATIENT DETAILS

Name: ______________ Surname: ______________

Date of birth: ______________________________

Medical aid name: ______________________________

Medical aid number: ______________________________

Tel: ______________ Fax: ______________ Email: ______________

Please specify NHRPL / LAB codes and tooth number/s, and attach a copy of the LAB quotation.

PROCEDURE DETAILS

NHRPL codes	Amount	Diagnosis code (ICD 10)	Tooth number/s	LAB codes	LAB amounts
	Total				Total

MOTIVATION FOR PROCEDURE

____

____

____

____

____

____

____

FOR DRC USE ONLY

Authorisation number ______________________________