

Authorisation form for specialised 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: _____

Name of theatre	Theatre practice number	Admission date

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 _____