SPECIALISED DENTISTRY APPLICATION FORM FOR DENTURES

Spectramed Reg No: 1141

Excluding consultations, radiographs (x-rays).

• CUSTOMER SERVICE CENTRE: 0861 497 497 • DEDICATED FAX LINE: 0861 492 492 •
• NATIONAL POSTAL ADRESS: Private Bag X1, Gardenview, 2047 •

INSTRUCTIONS TO COMPLETE THE APPLICATION FORM

Separate applications to be completed for different stages of treatment, excluding anaesthetist, hospital, dental laboratory and surgical assistant.

Please complete in block letters or typing.

Dental practitioner (provider) to complete the application form and member to sign the application form.

Please return completed application form to:

Fax: 0861 492 492

Email: dental@spectramed.co.za

Postal address: Private Bag X1, Gardenview, 2047

REQUIREMENTS AND EXCLUSIONS

Radiographs (x-ray photos) may be requested. Tooth numbers to be supplied for partial dentures.
Note 1: Radiographs (x-rays) will be returned to provider via postal delivery.
Note 2: Radiographs (x-rays) may be submitted via email.

SPECTRA AQUA OPTION – NO BENEFIT FOR SPECIALISED DENTISTRY

DATE OF APPLICATION YYYY MM DD

DATE OF DIAGNOSIS YYYY MM DD

SECTION 1. *MEMBER AND PATIENT'S INFORMATION*

MEDICAL SCHEME

SPECTRAMED OPTION

NAME & SURNAME OF MAIN MEMBER

MEMBERSHIP NUMBER

NAME & SURNAME OF PATIENT

DEPENDANT CODE

PATIENT DATE OF BIRTH YYYY

MEMBER TEL NO.

MEMBER CELLULAR NO.

MEMBER FAX NO.

MEMBER EMAIL ADDRESS

MEMBER'S POSTAL ADDRESS

AREA CODE

INITIAL

SECTION 2. *DENTAL PRACTITIONER'S INFORMATION*

PRACTICE NAME

PRACTICE NO.

PRACTICE TEL NO.

PRACTICE FAX NO.

PRACTICE EMAIL ADDRESS

PRACTICE POSTAL ADDRESS

AREA CODE

SECTION 3. *DENTURES*

CLINICAL MOTIVATION FOR THE PROPOSED TREATMENT:

ARE THERE ANY OTHER TREATMENT OPTIONS? IF NOT, PLEASE INDICATE REASON/S:

ANY OTHER ADDITIONAL INFORMATION/MOTIVATION TO BE TAKEN INTO CONSIDERATION REGARDING THIS CASE?

PLEASE INDICATE TOOTH NUMBERS BEING REPLACED BY DENTURES

NEW DENTURE

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

SECTION 4. *TARIFF CODES AND TARIFF AMOUNTS*

TARIFF CODE	DESCRIPTION	MODIFIER	TARIFF AMOUNT	QUANTITY	TOOTH NO. / MOUTH PART	PHASE	ICD 10 CODE

INITIAL

SECTION 5. *LABORATORY TECHNICIAN CODES*

TARIFF CODE	DESCRIPTION	MODIFIER	TARIFF AMOUNT	QUANTITY	TOOTH NO. / MOUTH PART	PHASE	ICD 10 CODE

INITIAL

SECTION 6. *DECLARATION*

All information disclosed in this form is subject to the rules of Spectramed Medical Scheme as amended from time to time.

Kindly note that the "Applicant" for the purposes of this form is the person who signs the declaration of this form.

1. I understand that the statements below apply equally to me and/or my dependants.
2. I declare that the contents of this application are true, correct and complete in every aspect.
3. I understand that certain benefits in the first year of my membership, once membership has been confirmed by Spectramed, are pro-rated and that I will not be entitled to a full year's cover if I join or change my existing option after 31 December of each year.
4. I understand that in terms of the Scheme rules, the Scheme portion is granted at 100% of Spectramed tariff for the particular year of the authorisation and is subject to the availability of the specialised dentistry limits, procedural sub-limits and with due consideration to the registered dental benefit exclusions.
5. I understand that should my active Scheme membership be terminated, for whatever reason, the authorised specialised dentistry benefit will no longer be applicable.
6. I understand that the authorised specialised dentistry benefit will only remain valid for as long as I belong to the same Spectramed option.
7. I understand that any specialised dentistry benefit authorisation provided is granted and strictly calculated upon the quotation (where applicable) as received from the dental practitioner (provider).
8. I consent to the processing of the information herein for purposes of marketing of value-added or similar products and services.

SIGNED AT

SIGNATURE OF APPLICANT

DATE OF SIGNATURE (YEAR/MONTH/DAY) YYYY MM DD

SIGNATURE OF PROVIDER

DATE OF SIGNATURE (YEAR/MONTH/DAY) YYYY MM DD