SPECIALISED DENTISTRY APPLICATION FORM FOR GENERAL ANAESTHETIC (GA)/SEDATION

Spectramed Reg No: 1141

• CUSTOMER SERVICE CENTRE: 0861 497 497 • DEDICATED FAX LINE: 086 506 2436 •
• 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: 086 506 2436

Email: dental@spectramed.co.za

Postal address: Private Bag X1, Gardenview, 2047

REQUIREMENTS AND EXCLUSIONS

Radiographs (x-ray photos) always needed for the following: for surgical extraction and impacted wisdom teeth

Note 1: Radiographs (x-rays) will be returned to provider via postal delivery.

Note 2: Radiographs (x-rays) may be submitted via email.

Orthognathic surgery, implant related surgery and placement of implant and flap surgery is a Scheme exclusion for in-hospital benefits applicable on all options, as per the registered Scheme Rules.

SPECTRA AQUA – NO BENEFIT FOR SPECIALISED DENTISTRY IN HOSPITAL

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 MM DD

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. *GENERAL ANAESTHETIC (GA) APPLICATION*

DATE OF ADMISSION YYYY MM DD

DURATION IN THEATRE

Hospital/Sedation Venue Information

HOSPITAL/SEDATION VENUE NAME

HOSPITAL/SEDATION VENUE PRACTICE NO.

PRACTICE TEL NO.

PRACTICE FAX NO.

SECTION 4. *SEDATIONIST / ANAESTHETIST DETAILS*

PRACTICE NAME

PRACTICE NO.

PRACTICE TEL NO.

PRACTICE FAX NO.

PRACTICE EMAIL ADDRESS

PRACTICE POSTAL ADDRESS

AREA CODE

INITIAL

SECTION 5. *CLINICAL MOTIVATION FOR TREATMENT TO BE DONE UNDER GENERAL ANAESTHETIC (GA)*

CLINICAL MOTIVATION FOR THE PROPOSED TREATMENT

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

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

SECTION 6. *TARIFF CODES AND TARIFF AMOUNTS*

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

INITIAL

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

SECTION 7. *DECLARATION*

All information disclosed in this form is subject to the rules of the 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

SIGNATURE OF PROVIDER

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

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

INITIAL