DENTAL PRE-AUTHORISATION
REQUEST FORM

prime cure health
leading integrated healthcare

A Dentist or Dental Therapist Details

Referring Doctor:
Practice Number:
Therapist:
Practice Number:
Dentist/Therapist Tel (W):
Dentist/Therapist Cell:
Dentist/Therapist Fax:
Dentist/Therapist Email:

Postal Address:
Code:

B Patient Details

Title:
Gender: Male ◯ Female ◯
First Name:
Surname:
Identity Number:
Tel (W):
Tel (H):
Cell:
Postal Address:
Employer:

Principal Member Surname:
Principal Member Initials:
Medical Scheme Name:
Medical Scheme Option:
Membership Number:
Dependant Code:
Email:
Code:

C The following benefits require pre-authorisation

5th or more Amalgam restorations per beneficiary per annum
Dentures and all Specialised Dentistry
5th or more non-surgical Extractions per beneficiary per annum
5th or more bite wing X-rays (maximum 4) per beneficiary per annum
5th or more Resin fillings (anterior only) per beneficiary per annum

D Essential Dentistry (Please specify relevant procedure codes/teeth numbers)

Procedure Codes	Teeth Numbers	Procedure Codes	Teeth Numbers	Procedure Codes	Teeth Numbers

E Denture Application (Full Upper & Lower/Full Upper or Lower/Partial denture)

Item	Procedure Codes	Co-Payment

F Clinical motivation for additional dental benefits

Signature:
Date: y y y y - m m - d d

Submit
Clear Form

G Pre-authorisation request procedure

Please note that application forms are to be completed in full and emailed to: dental.preauthorization@primecure.co.za. Should benefits be approved, a letter of authorisation will be faxed to the attending dentist / Dental Therapist within three (3) working days of receipt of this form and approval of benefits. Enquiries contact: Prime Cure 0860 665 665

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www.kaeloxelus.co.za