How to Complete an 'Oral Health Services for Adolescents' Claim Form

<u>Please read all instructions before beginning the claiming process.</u>

Step One

First, you must decide which form the patient should be claimed on. Choose **either** an Annual Consultation Only Treatment Report (for a patient that only had a 12 monthly consultation), **or** an Individual Treatment Report (for a patient that had a 12 monthly consultiation *plus* additional treatment) **or** an Exceptional Circumstances Treatment Report (for a patient who's care falls into the Exceptional Circumstances eligibility quota – refer to your **P**rincipal **D**ental **O**fficer or "**PDO**" for clarification).
<u>Please note:</u> A Patient must be entered on only one of these forms.

Step Two

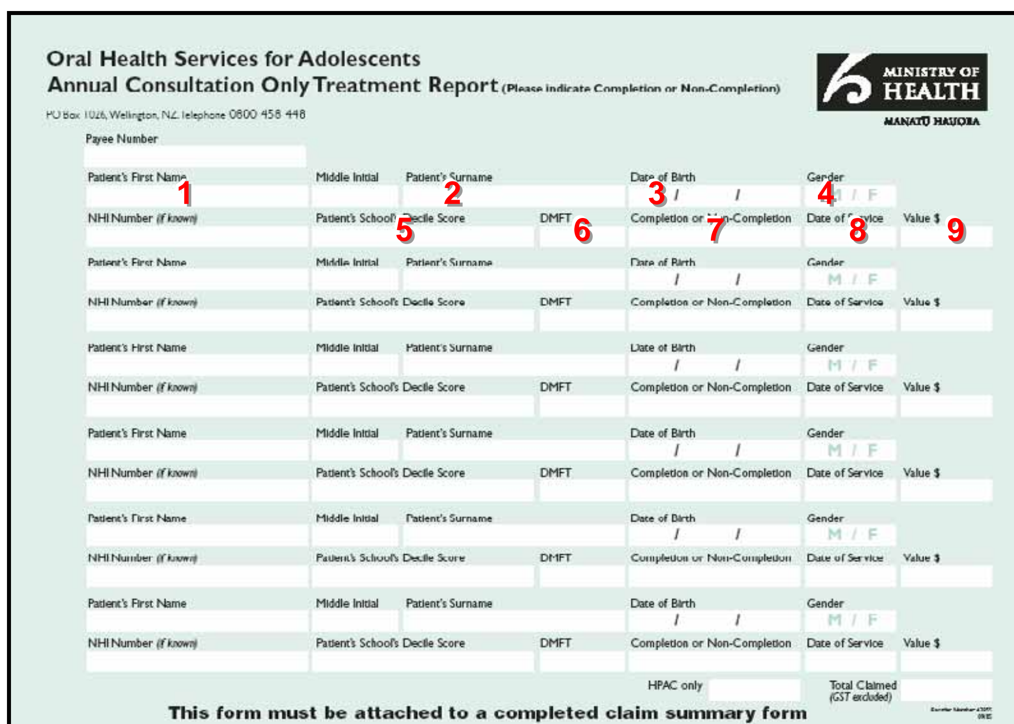
Select the patients that have **only** had a 12 monthly consultation and enter them onto the ***Annual Consultation Only Treatment Report.***

Enter the following information:

Mandatory fields are marked with a *. If any of these fields are left blank or incorrectly entered, the claim will be returned to you unpaid for amendment

- The patients first name, middle initial and surname*. **(See 1 – 2 below)**
- Patients date of birth and gender*. **(See 3 – 4 below)**
- The patients school's Decile score* and the appropriate 'Completion' or 'Non-Completion' code*, along with their DMFT score (mandatory if patient was 15 **or** 17 years old at the time of treatment). **(See 5, 6 & 7 below)**
  CODES: COM1, COM2, COM3, NCO1, NCO2, NCO3 – Refer to the reverse of Claim Summary Form for description of these codes.
- The date of service*. **(See 8 below)**
- Finally, you need to enter the value of the service you are claiming*. **(See 9 below)**
  <u>Note:</u> Please refer to the latest version of your Combined Dental Agreement for the appropriate Fee Schedule.
- At the bottom of the form, calculate the total (GST exclusive) for each page of Annual Consultation's that you complete. **(See 10 below)**

Repeat for each patient – up to 6 patients can be claimed per form.


Oral Health Services for Adolescents
Annual Consultation Only Treatment Report (Please indicate Completion or Non-Completion)
PO Box 1026, Wellington, NZ. Telephone 0800 458 448
MINISTRY OF HEALTH
MANATŪ HAUORA

Payee Number

Patient's First Name | Middle Initial | Patient's Surname | Date of Birth / / | Gender M / F
NHI Number (if known) | Patient's School's Decile Score | DMFT | Completion or Non-Completion | Date of Service | Value $

Patient's First Name | Middle Initial | Patient's Surname | Date of Birth / / | Gender M / F
NHI Number (if known) | Patient's School's Decile Score | DMFT | Completion or Non-Completion | Date of Service | Value $

Patient's First Name | Middle Initial | Patient's Surname | Date of Birth / / | Gender M / F
NHI Number (if known) | Patient's School's Decile Score | DMFT | Completion or Non-Completion | Date of Service | Value $

Patient's First Name | Middle Initial | Patient's Surname | Date of Birth / / | Gender M / F
NHI Number (if known) | Patient's School's Decile Score | DMFT | Completion or Non-Completion | Date of Service | Value $

Patient's First Name | Middle Initial | Patient's Surname | Date of Birth / / | Gender M / F
NHI Number (if known) | Patient's School's Decile Score | DMFT | Completion or Non-Completion | Date of Service | Value $

Patient's First Name | Middle Initial | Patient's Surname | Date of Birth / / | Gender M / F
NHI Number (if known) | Patient's School's Decile Score | DMFT | Completion or Non-Completion | Date of Service | Value $

HPAC only | Total Claimed (GST excluded)

This form must be attached to a completed claim summary form

STEP 3

Select the patients that have had a 12 monthly consultation *plus* additional treatment (except those to be claimed on an Exceptional Circumstances Treatment Report) and enter them onto the ***Individual Treatment Report.***

Only 1 patient per report.

Enter the following information (See section "1" on form below)

Mandatory fields are marked with a *. If any of these fields are left blank or incorrectly entered, the claim will be returned to you unpaid for amendment:

- The patients surname, first name and middle initial.*
- Patients date of birth and gender.*
- Patients DMFT score
- Patients School name and decile score.* If patient is not currently attending secondary school, please state their current situation – decile score becomes **5**.

There are 3 sections in the claim detail part of this form, and specific information is required in each.

Section 1
Standard Oral Health Services
(See section "2" on form below)
(Refer to Part 3, Schedule F2 of the Oral Health Services Agreement for fees claimed in this section).

Enter the appropriate codes for the following treatments (refer to reverse of Claim Summary Form for a description of these codes):

- 12 Monthly consultation **(COM1, COM2, COM3, NCO1, NCO2, NCO3)**
- Annual, 6 monthly, emergency in practice hours and emergency after practice hours consultations **(CON1, CON2, CON3, CON4).**
- One surface filling in posterior teeth **(FIL1)**
- Periapical radiography **(RAD1)**
- Fissure Sealant **(FIS1)**
- Topical fluoride treatment **(TOP1)**
- Other preventative treatment **(OPT1)**

Enter the following information for each treatment provided:

- The date of treatment
- Under the heading of 'Tooth', enter the number(s) of the tooth/teeth on which the treatment was performed.

Section 2
Additional Oral Health Services (Not requiring Prior PDO Approval)
(See section "3" on form below)
(Refer to Part 3, Schedule F4 of the Oral Health Services Agreement for fees claimed in this section).
In this section enter all other treatment that does not require PDO approval.

Enter the following information:
Mandatory fields are marked with a *. If any of these fields are left blank or incorrectly entered, the claim will be returned to you, unpaid, for amendment.

- The date of treatment. *
- The appropriate code (see back of Claim Summary for codes). *
- Any relevant comments if necessary.
- Under the heading 'Quantity', enter the number of treatments being claimed for on this line.
- Under the heading 'Tooth' enter the number(s) of the tooth/teeth on which the treatment was performed (Mandatory for selected treatments, refer to Combined Dental Agreement)
- Under the heading 'Value - $' enter the total of fees being claimed for on this line *

Section 3

Additional Oral Health Services Requiring Prior PDO Approval

(See section "4" on form below)

(Refer to Part 3, Schedule F5 of the Oral Health Services Agreement for fees claimed in this section).

In this section enter all other treatment that *does* require prior PDO approval.

Enter the following information for each treatment provided:

Mandatory fields are marked with a *. If any of these fields are left blank or incorrectly entered, the claim will be returned to you, unpaid, for amendment.

- The PDO Approval number *
- The date of the treatment *
- The appropriate code (see reverse of Claim Summary form) *
- Any relevant comments
- Under the heading 'Quantity', enter the number of treatments being claimed for on this line
- Under the heading 'Tooth' enter the number(s) of the tooth/teeth on which the treatment was performed (Mandatory for selected treatments, refer to Combined Dental Agreement)
- Under the heading 'Value - $' enter the total of fees being claimed for on this line *

Note: The claim will not be paid if the PDO approval number is not entered or supplied.

MINISTRY OF HEALTH

MANATŪ HAUORA

Oral Health Service for Adolescents
Individual Treatment Report

PO Box 1026, Wellington, NZ. Telephone 0800 458 448

Patient NHI (if known)

Patient's Surname (BLOCK LETTERS) **1** Patient's First Name (BLOCK LETTERS)

Date of Birth / / Gender M / F DMFT if aged 15 DMFT if aged 17

School attended (if appropriate) School Decile Score

Standard Services (Annual Consultations and all treatments included in the Capitated Package)

Date of Annual Consultation - CON1	/ /	Completed Y/N		Annual Capitated Fee (GST exclusive)	$	HPAC only

2

Date of Treatment	Code	Completed (✓)
	CON2	
	CON3	
	TOP1	
	OPT1	
	RAD1	

Date of Treatment	Code	Tooth	Completed (✓)
	FIL1		
	FIS1		

Additional Services Not Requiring Prior Approval **3**

Date of Treatment	Code	Comment	Quantity	Tooth	Value $	HPAC Only

Additional Services Requiring Prior Approval Approval No. **4**

			Total Claimed (GST exclusive)		$	$

This form must be attached to a completed claim summary form

Reorder Number: [illegible]

STEP 4

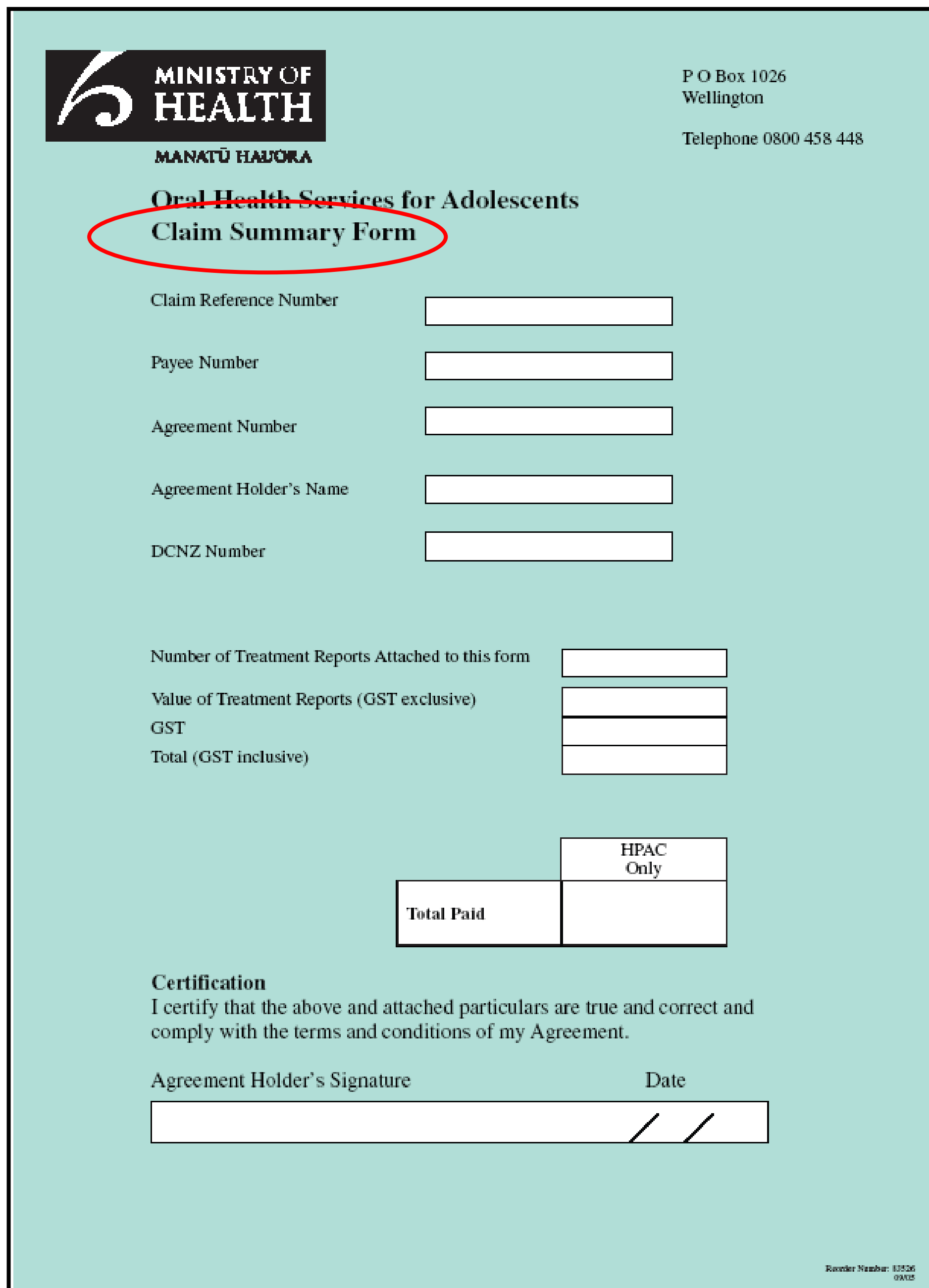
When all the Annual Consultation Only Treatment Reports and all the Individual Treatment Reports have been completed, the information from them is then brought together and summarized on a ***Claim Summary Form***.

Enter the following information on this form:

Mandatory fields are marked with a *. If any of these fields are left blank or incorrectly entered, the claim will be returned to you, unpaid, for amendment.

- The Provider Claim Reference number
- The Provider's Payee number *
- The Provider's Agreement/Contract number *
- The Agreement Holder's name *
- Enter the number of Treatment Reports attached to this form
- Calculate and enter the value of Treatment Reports (GST exclusive) *
- Calculate the GST
- Add the GST amount to the sub-total and enter the total amount of the treatments being claimed in the "Total Claimed" field. *
- Ensure the Provider signs and dates the form at the bottom of the page. *

Note: The claim will not be paid if the Providers signature is missing.



MINISTRY OF HEALTH
MANATŪ HAUORA

P O Box 1026
Wellington

Telephone 0800 458 448

Oral Health Services for Adolescents
Claim Summary Form

Claim Reference Number

Payee Number

Agreement Number

Agreement Holder's Name

DCNZ Number

Number of Treatment Reports Attached to this form

Value of Treatment Reports (GST exclusive)

GST

Total (GST inclusive)

HPAC Only

Total Paid

Certification

I certify that the above and attached particulars are true and correct and comply with the terms and conditions of my Agreement.

Agreement Holder's Signature

Date / /

STEP 5

Attach all Treatment Reports to the back of the Claim Summary form and Send to:

HealthPAC
P.O. Box 1026
WELLINGTON

STEP 6

Select all patients that fall into the category 'Exceptional Circumstances' and submit them on the ***Exceptional Circumstances Treatment Report***. If you are unsure, check with your Principal Dental Officer. Each patient requires a separate form, and Prior approval.

Enter the following information onto this form:

Mandatory fields are marked with a *. If any of these fields are left blank or incorrectly entered, the claim will be returned to you, unpaid, for amendment.

- The Provider Claim Reference Number
- The Provider's Payee and Agreement numbers. *
- The Agreement Holder's name *
- The Patients surname, first name and middle initial (IN BLOCK LETTERS) *
- Patient's date of birth and gender. *
- Patient's School and decile score. *
- Enter patients DMFT score
- Enter the PDO Approval number in the field marked "Approval Number" *

For each treatment provided, enter:

- Treatment date *
- Appropriate code (see back of Summary form) *
- Any relevant comments
- Under the heading 'Quantity' enter the number of treatments being claimed for on this line
- Under the heading 'Tooth' enter the number(s) of the tooth/teeth on which the treatment was performed *
- Under the heading 'Value - $' enter the total of fees being claimed for on this line *

Then:

- Add all fees together and enter in Total (GST exclusive) field. *
- Calculate the GST, add it to the sub-total and enter the total of the claim in the 'Total claimed' field. *
- Ensure the Provider signs and dates the form at the bottom of the page. *

Note: The claim will not be paid if the PDO approval number is not entered or if the Providers signature is missing.

Provider and Patient details

Approval number and treatment details

Totals, Provider's signature and date of claim.

MINISTRY OF HEALTH
MANATŪ HAUORA

Oral Health Services in Exceptional Circumstances (Adolescents) Treatment Report / Claim Summary Form

P O Box 1026, Wellington, NZ. Telephone 0800 458 448

Claim Reference Number | Payee Number | Agreement Number

Agreement Holder's Name | DCNZ Number

NHI Number (if known)

Patient's Surname (BLOCK LETTERS) | Patient's First Name (BLOCK LETTERS)

Date of Birth / / | Gender M / F | DMFT if aged 15 | DMFT if aged 17

School attended (if appropriate) | School Decile Score

Approval No.

Date of Treatment	Code	Comments	Quantity	Tooth	Value $	HPAC Only

Total (GST exclusive)
GST
Total Claimed (GST inclusive)

Certification
I certify that the above particulars are true and correct and comply with the terms and conditions of my Agreement.

Agreement Holder's Signature
Date / /