

# HOW TO COMPLETE A 'SPECIAL DENTAL SERVICES' CLAIM FORM

Please ensure you read all instructions prior to beginning the claiming process.

## **STEP 1**

This form is to be used either for children who have been referred by the school dental service or for children or adolescents who have been treated as an emergency patient when unable to access the school dental therapist or their usual dentist. Use one report per patient.

**Ensure that the patient or their legal guardian has completed the top portion of the form on entering your practice and prior to receiving treatment.**

**All boxes must be completed as applicable and the ethnicity question must be answered by the patient.**

## **STEP 2**

Treatment boxes provide the reason for the patient's consultation. Please tick the box appropriate for the treatment provided and the category of the patient.

Below are the specifications for each treatment box:

### **Treatment Box 1**

*A referral number and/or referral form is required.*

- Patients who are eligible to claim under Treatment Reason **#1** are referred by their usual Dental Therapist for work beyond the therapist's capacity. If the referral letter is provided, a photocopy should be taken and attached to the claim and the original copy sent to the Principal Dental Officer (**P.D.O.**) along with the duplicate copy

Note: The claim will be declined and returned for amendment if a box is not ticked.

### **Treatment Box 2**

*The usual School, Dental Clinic and Town/City of the patient is required*

- Patients who are eligible to claim under Treatment Reason **#2** are children who are enrolled in the School Dental Service, and are referred by their Dental Therapist. If neither a referral form nor a referral number is provided, the name of the referring Dental Clinic is required.

### **Treatment Box 3**

*The name of the School Dental Clinic and the patient's Town/City of residence is required.*

- Patients who are eligible to claim under Treatment Reason **#3** are children who are enrolled with a Provider/Dentist, but require treatment during the school holidays or after hours.

### **Treatment Box 4**

*The name of the patient's Provider (Usual Dentist) and the patient's Town/City of residence are required.*

- Patients who are eligible to claim under Treatment Reason **#4** are children who require emergency care are enrolled with another Provider/Dentist

### **Treatment Box 5**


*No information is required.*

- Patients who are eligible to claim under Treatment Reason **#5** are pre-school, primary school or intermediate school children. These children will neither be enrolled with the School Dental Service nor be a private patient of a dentist.

**STEP 3**

In the appropriate section in the bottom portion of the form, (either standard services or services requiring prior approval), enter the following information:

- Date of treatment **(See 1 below)**
- Treatment code (see the back of the Claim Summary form). **(See 2 below)**
- Any relevant comments **(See 3 below)**
- School dental referral number or approval number (where applicable)
- Under quantity enter the number of treatments being claimed on this line **(See 4 below)**
- Under the heading 'Tooth', enter the number(s) of the tooth/teeth on which the treatment was performed. **(See 5 below)**
- Under 'Value - \$' enter the total of the fees being claimed on this line **(See 6 below)**
- Add all fees together and enter in 'Total Claimed' (GST exclusive) **(See 7 below)**



**MINISTRY OF HEALTH**  
MANATŪ HAUORA

**Special Dental Service Agreement  
Individual Treatment Report**  
P O Box 1026, Wellington, Telephone 0800 458 448

**TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN**

<p>NHI Number (if known) <input style="width: 100%;" type="text"/></p> <p>Patient's Surname (BLOCK LETTERS) <input style="width: 100%;" type="text"/></p> <p>Patient's First Name (BLOCK LETTERS) <input style="width: 100%;" type="text"/></p> <p>Address of Patient <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/></p> <p>Date of Birth <input style="width: 30%;" type="text" value="/"/> <input style="width: 30%;" type="text" value="/"/> <input style="width: 30%;" type="text"/></p> <p>Gender <input style="width: 30%;" type="text" value="M"/> <input style="width: 30%;" type="text" value="/"/> <input style="width: 30%;" type="text" value="F"/></p> <p>Name of School/Dental Clinic <input style="width: 100%;" type="text"/></p> <p>Town/City of School/Dental Clinic <input style="width: 100%;" type="text"/></p> <p>Name of Usual Dentist <input style="width: 100%;" type="text"/></p> <p>Town/City of Usual Dentist <input style="width: 100%;" type="text"/></p>	<p>Which ethnic group do you belong to? <i>Mark the space or spaces that apply to you.</i></p> <p><input type="radio"/> New Zealand European</p> <p><input type="radio"/> Māori</p> <p><input type="radio"/> Samoan</p> <p><input type="radio"/> Cook Island Māori</p> <p><input type="radio"/> Tongan</p> <p><input type="radio"/> Niuean</p> <p><input type="radio"/> Chinese</p> <p><input type="radio"/> Indian</p> <p><input type="radio"/> other (such as DUTCH, JAPANESE, TOKELAUAN). Please state: <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/></p> <p style="font-size: small; text-align: right;"><i>New Zealand Census of Population and Dwellings, March 2001</i></p>
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**TO BE COMPLETED BY AGREEMENT HOLDER**

The required treatment was (tick applicable box)

1. As approved: Approval form attached (if form not attached write Referral No.)

2. Emergency care for a child enrolled in the School Dental Service. Give name of patient's School Dental Clinic if available.

3. Treatment for a child enrolled in the School Dental Services who was presented to you without referral by a school dental nurse.

4. Emergency care for a child enrolled for Adolescent Oral Health Services with another Provider.

5. Emergency care for a pre-school, primary, intermediate or adolescent school child who is neither enrolled with the School Dental Service nor a private patient of a dentist.

Date of Treatment	Code	Comments	Quantity	Tooth	Value \$	HPAC Only
<b>Standard Services Not Requiring Prior Approval</b>			School Dental Referral Number:			
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	
<b>Services Requiring Prior Approval</b>			Approval Number:			
Total Claimed (GST exclusive)					<b>7</b>	\$

**This form must be attached to a completed claim summary form**

Revised Number: 85529 08/05

#### **STEP 4**

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

Enter the following information on this form:

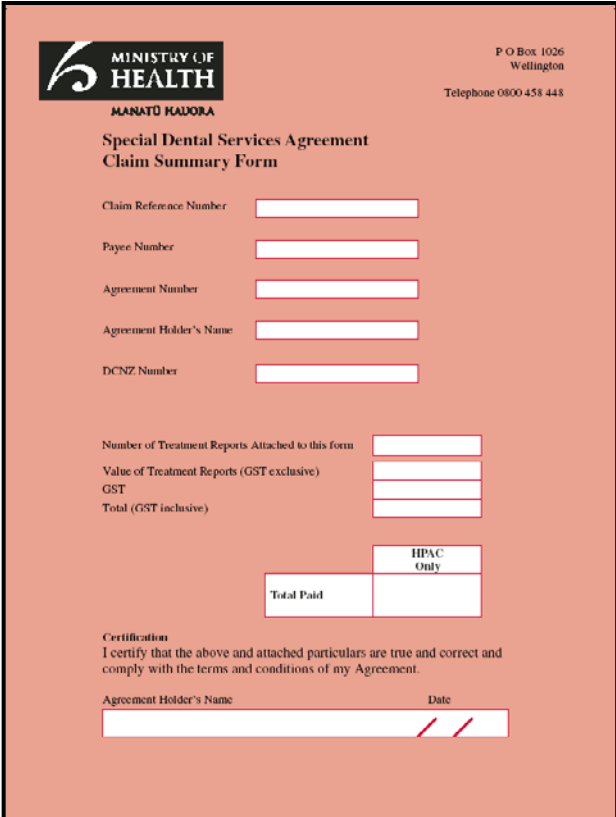
- The Claim Reference number
- The Payee number of the Provider
- The Agreement number of the Provider
- The Agreement Holder's name
- The number of Treatment Reports attached to the form
- The value of the attached treatment reports together (GST *exclusive*)
- The GST amount, then the total (GST *inclusive*)
- Ensure the Dentist signs and dates the form at the bottom of the page below the certification.

**Note:** Failure to provide any of the above information may result in the claim being returned to you, unpaid.

#### **STEP 5**

When forms are completed, attach all Special Dental Service Agreement Individual Treatment Reports to the back of the Claim Summary form (along with the duplicate's that are required) and submit to;

**HealthPAC  
P.O. Box 1026  
WELLINGTON**



The form is titled "Special Dental Services Agreement Claim Summary Form" and is issued by the Ministry of Health (Manatū Hauora). It contains several input fields for claim details, a table for treatment report values, a signature line, and a date field. The form is set against a light red background.

**MINISTRY OF HEALTH**  
MANATŪ HAUORA

P O Box 1026  
Wellington  
Telephone 0800 458 448

**Special Dental Services Agreement  
Claim Summary Form**

Claim Reference Number

Payee Number

Agreement Number

Agreement Holder's Name

DCNZ Number

Number of Treatment Reports Attached to this form	<input type="text"/>
Value of Treatment Reports (GST exclusive)	<input type="text"/>
GST	<input type="text"/>
Total (GST inclusive)	<input type="text"/>

	HPAC Only
Total Paid	<input type="text"/>

**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 Name  Date