Post Office MEDIPOS Medical Scheme

Putting your wellbeing first

APPLICATION FORM
REQUEST FOR DENTAL IMPLANT THERAPY

All sections of this form must be completed by the member and the dental practitioner before submitting the request to the Scheme. The Scheme will provide the member with written confirmation whether benefits are granted. X-rays must be included. **PLEASE USE BLOCK LETTERS.**

INFORMATION OF MEMBER/PATIENT

Name of member

Membership number

Telephone number

Cell phone

Email address

Name of patient

Patient's date of birth D D M M Y Y Y Y

Patient's general health

MOTIVATION FOR IMPLANTS FOR PATIENT

TO BE COMPLETED BY CO-ORDINATING DENTAL PRACTITIONER

Teeth currently present

☐ 1st quadrant _____ ☐ 2nd quadrant _____

☐ 3rd quadrant _____ ☐ 4th quadrant _____

Positions where implants are planned

☐ 1st quadrant _____ ☐ 2nd quadrant _____

☐ 3rd quadrant _____ ☐ 4th quadrant _____

Present state of oral hygiene

☐ Poor ☐ Average ☐ Good ☐ Excellent

Why are implants considered as the treatment of choice?

Continued overleaf »

MOTIVATION FOR IMPLANTS FOR PATIENT (CONTINUED)

TO BE COMPLETED BY CO-ORDINATING DENTAL PRACTITIONER

Name of practitioner

Practice number

Telephone number

Fax number

Email address

SURGICAL PHASES

TO BE COMPLETED BY THE DENTAL PRACTITIONER WHO WILL PERFORM THE PREPARATORY PHASES, 1AND 2 (WHERE APPLICABLE)

Name of practitioner

Practice number

Telephone number

Fax

Email address

PREPARATORY PHASE (SINUS LIFT, RIDGE AUGMENTATION, ETC.)

Provisional service date/s

Hospital details

Procedure code/s excluding theatre and anaesthetist's costs

Tariff codes	Description	Tariff amount

Assistant ☐ Yes ☐ No

PHASE 1 (PLACEMENT OF OSSEO-INTEGRATED IMPLANTS)

Provisional service date/s

Procedure code/s including cost of components, excluding theatre and anaesthetist's costs

Tariff codes	Description	Tariff amount

Cost of implant invoice required. Should phase 1 be performed under general anaesthesia (GA), a separate application is required.

NOTE: One implant will not be considered for GA.

Membership no.

Practice no.

SURGICAL PHASES (CONTINUED)

TO BE COMPLETED BY THE DENTAL PRACTITIONER WHO WILL PERFORM THE PREPARATORY PHASES, 1AND 2 (WHERE APPLICABLE)

PHASE 2 (EXPOSURE OF OSSEO-INTEGRATED IMPLANTS)

No benefits will be granted for treatment performed under GA for this phase.

If no exposure phase, include motivation as to why and what types of implants are being used.

Estimated integration period prior to exposure

Procedure code/s including cost of components, excluding theatre and anaesthetist's costs

Tariff codes	Description	Tariff amount

Assistant ☐ Yes ☐ No If no, please include the laboratory quotation

PROSTODONTIC PHASE

TO BE COMPLETED BY THE DENTAL PRACTITIONER WHO WILL CARRY OUT PHASE 3

Name of practitioner

Practice number

Telephone number Fax number

Email address

PHASE 3 (CROWNS, BRIDGES, DENTURES, ETC.)

X-rays required.

Provisional service date/s

Procedure code/s including cost of implants and laboratory fees

Tariff codes	Description	Tariff amount

Exposition in the event that all prosthodontic services are not intended to be completed simultaneously

Signature (phase 3 practitioner) _____

Continued overleaf »

Membership no. Practice no.

PROSTODONTIC PHASE (CONTINUED)

PHASE 3 (CROWNS, BRIDGES, DENTURES, ETC.) (CONTINUED)

IMPORTANT: Please indicate if the laboratory account will be claimed separately by the dental laboratory.

☐ Yes ☐ No If no, please include the laboratory quotation.

PATIENT CONSENT

1. I hereby confirm that the information provided in this application is true and correct.
2. I acknowledge that Medscheme MEDiPOS Business Unit (Pty) Ltd is the administrator of the programme and that any dental treatment provided, taking into consideration my oral health status and general health, will be the sole responsibility of my dental practitioners, in consultation with myself. Medscheme MEDiPOS Business Unit and the Scheme and/or employer will accordingly not be held liable for any claims by me or my dependants arising from the implementation of the programme.
3. I hereby give my consent to Medscheme MEDiPOS Business Unit, including their agents and dental staff, to obtain my special personal information (i.e. health and biometric) from my healthcare providers (dentists, dental specialists, pharmacists, pathologists, medical practitioners and radiologists) to assess my medical risk and enrol me on the programme and to use such information to my benefit. I understand and agree that special personal information relevant to my current state of health can be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.
4. I understand that no information regarding my case will be made available to my employer/s or any other person not directly involved in my care.
5. I give my consent to Medscheme MEDiPOS Business Unit to electronically store, access, process and retain my special personal information for the purposes set out in this document as may otherwise be required to administer the programme.
6. While Medscheme MEDiPOS Business Unit undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Scheme and/or employer and practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Medscheme MEDiPOS Business Unit liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I shall be entitled to terminate my participation in the programme at any time with immediate effect on notice to the Scheme, but understand that all benefits that I enjoyed under the programme shall immediately cease and the Scheme shall not be obliged to reinstate such benefits at any time thereafter. I understand that the consequences of such a decision will rest with me alone.
8. I understand that telephone calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the programme.
9. I understand and acknowledge that 'consent', for the purposes of this document, means my informed consent, in other words:
   - 9.1 I have read and understood the contents of this document.
   - 9.2 I understand and acknowledge the nature and purpose for which the personal medical information that will be made available to and disclosed, used, processed and retained by the Scheme and my healthcare providers, as set out in this consent.
   - 9.3 I have the legal capacity to give my informed consent, in other words, I am over the age of 18 and am able to fully understand and make decisions about my healthcare.

Patient's signature
(or signature of parent/guardian if patient is under the age of 18)

D	D	M	M	Y	Y	Y	Y

Date

Membership no. | | | | | | | | | | | | | |

Practice no. | | | | | | | | | | | | | |

01/20

Return address: MEDiPOS Dental Management Programme, PO Box 921, Westville, 3629
Tel 0860 100 078 **Fax** 0865 608 087 **Email** dental@medipos.co.za