Newfoundland Labrador

DENTAL HEALTH PLAN
PRIOR APPROVAL APPLICATION

PATIENT IDENTITY NUMBER / MCP NUMBER

PATIENT SURNAME (please print)

GIVEN NAME (please print)

INCOME SUPPORT NUMBER

INCOME SUPPORT FILE NUMBER

CO-INSURANCE ☐ Yes or ☐ No

PROVIDER NUMBER

PROVIDER SURNAME

PROVIDER GIVEN NAME

PRIOR APPROVAL IS BEING REQUESTED FOR THE FOLLOWING SERVICES:

Adult Dental Fee Code	Tooth #	Surfaces M O D V L	Units	Fee Requested	Priority	Amount Eligible (MCP USE ONLY)

EMERGENCY: Exams, x-rays, and extraction(s)

☐ Patient seen as a result of pain, infection, or trauma.

☐ Patient seen with immediacy - walk in or same day appointment.

☐ Treatment deals only with presenting chief complaint.

DENTURES

Adult Dental Fee Code	Units	Is this a replacement? Yes or No	Age of Existing Dentures	Fee Requested	Amount Eligible (MCP USE ONLY)
			years		
			years		
			years		
			years		

ORTHODONTICS

Requested: Initial Amount | Monthly | To a Maximum of

ADDITIONAL INFORMATION:

PROVIDERS SIGNATURE

DATE

Day Month Year