ACC 4231

DENTAL TREATMENT

Orthodontic Treatment Prior Approval

PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

Complete this form to request prior approval for orthodontic treatment.

1. CLIENT DETAILS

Client's name:	Date of birth:
Claim number:	Date of injury:

2. QUESTIONS

Please tick the box(es) below to show the extent that the occlusion has been affected by the trauma.

- ☐ Displacement of one or more teeth (in any direction)
- ☐ Drift of teeth as a consequence of loss
- ☐ Loss of one or more teeth
- ☐ Questionable relationship between trauma and malocclusion
- ☐ Trauma to deciduous teeth that may have influenced the positioning of the permanent teeth.

Is there a pre-existing malocclusion? ☐ Yes ☐ No

If yes, are you treating the pre-existing malocclusion as well as the trauma-related malocclusion? ☐ Yes ☐ No ☐ n/a

If you were to treat **only** the trauma-related malocclusion to the pre-trauma status of the dentition, what is the simplest method of doing so?

- ☐ Removable appliance
- ☐ Sectional arch
- ☐ Single arch
- ☐ Upper and lower arch treatment
- ☐ Fixed appliances combined with other dental specialities
- ☐ TAD (temporary anchorage device)

What is your total fee for the treatment? (GST exclusive)

Estimate the percentage of the total treatment fee that could be attributable to the trauma-related malocclusion? %

Would additional orthodontic treatment be required in the future? ☐ Yes ☐ Probably ☐ Unlikely ☐ No

If yes, please state why, and whether the current treatment plan can be deferred:

Has your application for orthodontic treatment been made at the request of the parent/caregiver? ☐ Yes ☐ No ☐ n/a

3. DETAILED TREATMENT

Please provide details of your treatment plan and, if required, attach any additional information.

4. ENCLOSED DIAGNOSTICS

Please tick the box(es) to indicate the diagnostics/notes that you have included with this application.

- ☐ Photographs
- ☐ Models
- ☐ Treatment notes
- ☐ Radiographic: ☐ *Panoramic* ☐ *Cephalogram* ☐ *Intra-oral* ☐ *Other:*

5. ORTHODONTIST DETAILS

Name:	Signature:	Request date:	Provider number:

The information collected on this form will only be used to fulfil the requirements of the Accident Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994. ACC has the right to request information for audit purposes, ie diagnostics and treatment records.