ضمان
مجلس الضمان الصحي
Council of Health Insurance

ملحق رقم (2)

نموذج طلب الموافقات والمطالبات

للأسنان

DCAF

ملحق رقم (2): نموذج طلب الموافقات والمطالبات للأسنان

Appendix no. (2): DCAF

إشارةً إلى الملحق رقم (2) من اللائحة التنفيذية لنظام الضمان الصحي التعاوني لمعايير طلب الموافقة على تحمل تكاليف العلاج، التي أوضحت الإجراءات المتبعة في حال طلب الموافقة من قبل المرافق الصحية ومسئوليات شركات التأمين للالتزام بما ورد فيها. النموذج الموحد يجب أن يتضمن جميع المعلومات الأساسية المذكورة فيه وأن يتم الالتزام بمعايير الترميز المعتمدة من المجلس وأن تكون الخدمات حسب قوائم الأسعار المتفق عليها حسب النموذج رقم (6). هذا النموذج يجب أن يكون جزء من متطلبات المطالبة التي ترسل من قبل المرفق الصحي إلى شركة التأمين.	Referring to Appendix No. (2) of the executive regulations of CCHI for the criteria of requesting approval to bear the costs of treatment, which clarified the procedures followed in the event that approval is requested by healthcare providers and the responsibilities of insurance companies to comply with what is stated therein. The Dental form must include all the basic information mentioned in it, the coding standards approved by the council must be adhered, and the services must be according to the price lists agreed upon according to form No. (6) in this contract. This form should be part of the claim requirements that are sent by the healthcare providers to the insurance company.

DCAF 2.0

To be completed & ID verified by the reception/nurse:

Provider Name:

Insurance Company Name:

TPA Company Name:

Patient File Number:

Data of visit / /

Plan Type ( ) New visit ( ) I Follow Up ( )

Print/Fill in letters or Emboss Card:

Insured Name:

ID. Card No. Sex Age

Policy Holder Policy No

Expiry Data / /

Class

To be completed by the Dentist:

Duration of Illness. ..... (Days).

Chief Complaint & Main symptoms .....

.....

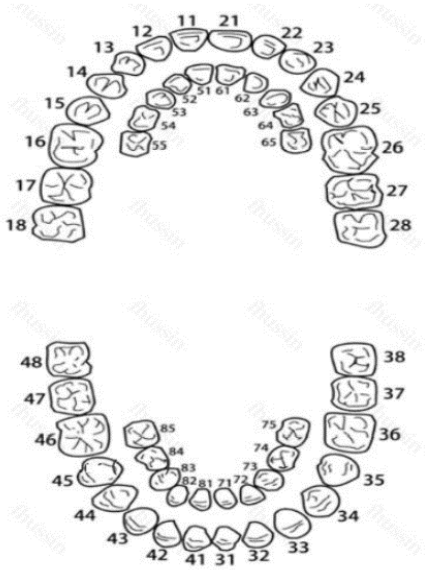
Significant Signs: .....

Diagnosis (ICD10) .....

Primary .....

Secondary .....

Other conditions .....



Please tick (✓) where appropriate:

Regular Dental Treatment ( ) Dental Cleaning ( )

Trauma Treatment Specify: RTA ( ) Work Related ( ) Other.....

How:

When: ..... Where: .....

Specify The recommended procedures using the tooth number as shown on the teeth map above:

Code	Dental / Service	Tooth No.	Cost
		Total	

Providers Approval/Coding Staff must review/code the recommended service(s), allocate cost, and complete the following:

Completed/Coded BY Signature Data / /

Medication Name (Generic Name)	Type	Quantity

I hereby certify that All information mentioned are correct and that the medical services shown on this form were medically indicated and necessary for the management of this case.

Dentlist Signature Stamp Date

/ /

I hereby certify that All statements and information provided concerning patient identification and the present illness or injury are TRUE.

Name and relationship (if guardian):

Signature (*) Data / /

For Insurance Company Use Only: Approved ( ) Not Approved ( ) Approval No: Approval Validity: Days

Comments (include approved days/services if different from the requested)

Approved/Disapproved by Signature Data / /

(*)This is applicable only in case of manual DCAF