DCAF 1.0

To be completed by reception / nurse

Provider Name : ______________________________________

Insurance Co :______________________________________

TPA Name :______________________________________

Patient file No _______________ *Date of visit* / /

Plan Type :________________ ☐ *new Visit* ☐*Follow Up / Refill*

To be completed by Attending DENTIST *:*

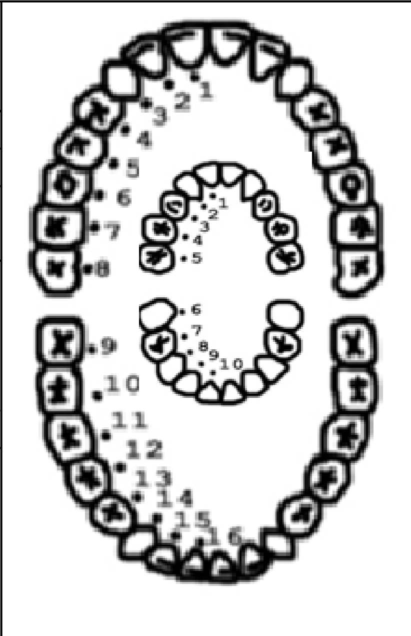
Duration of illness : ……………………………………………………

Chief Complaint & Main Symptoms:…………………………………………………………………………………………
………
………

Diagnosis :……

Principal Code : ______________ **2nd code** : ______________ **3rd code** : _______________

Other Conditions Diagnosis : ………………………………………………………………………………………………
………



Please Tick (X) Where Appropriate :

☐ **RTA** ☐ **work Related** ☐**Sports Related**

☐ Orthodontics \ Esthetics ☐Congenital\ Developmental

☐Check Up ☐ Cleaning

Specify the recommended investigations and/or procedures using the tooth number as shown on the teeth map above

Code	Description/ Service	Quantity	Type	Cost
			Total	

I herby certify that all information mentioned are correct & that the medical services shown on this form were medically indicated & necessary for the management of this case .
Physician Signature & Stamp ________________________________
Date : / /

I hereby certify that all statements & information provided concerning patient I identification & the present illness or injury are **TRUE**

_________________________ ________________
Name & relationship (if guardian) Signature Date / /

Provider's Approval / coding staff must review / code the recommended service (s) & allocate cost and complete the following :
Complete / code by : …………………………………………………… Signature : …………………………………………………………………… Date ………… / …… / ……….

For insurance Company Use Only ☐ Approved ☐ Not Approved Approval No : …………………………..

Comments : (*include approved days / services, if different the requested*) Approval Validity …………………….

………
………
………

Insurance Officer __________________________________ **Signature :** ______________________________ **Date :** / /