NEW BRUNSWICK CLEFT PALATE PROGRAM PRE-AUTHORIZATION FORM

(to be completed by the dental provider)

CLIENT INFORMATION

Name ____
Last First Initial(s)

Medicare Number ____________________ Date of Birth ____________________

PROVIDER INFORMATION

Name ____________________ Unique Number ____________________

Address ____

____

Has this child been diagnosed with Cleft of the hard palate? ☐ Yes ☐ No

Please complete the section below that best describes the required treatment at this time.

Phase I - Initial Treatment ie. consultation, feeding appliance, obturator, orthodontic records (which includes examinations, X-rays and treatment planning). Please provide a projection of cost - standard office forms are acceptable.

Description of Service	Expected Duration	Projection of Fee

Phase II - Orthodontics (Please identify the course of treatment, the expected duration and a projection of the cost - standard office forms are acceptable.)

Description of Service	Expected Duration	Projection of Fee

Phase III - Prosthodontics (Please identify the course of treatment, the expected duration and a projection of the cost - standard office forms are acceptable.)

Description of Service	Expected Duration	Projection of Fee

Signature of Provider ______________________________ Date ____________________

PLEASE RETURN TO CLIENT WHEN COMPLETED.

If you have any questions or concerns, please call 1-888-273-0666.