

## PRIOR AGREEMENT APPLICATION - DENTAL TREATMENTS

Major dental treatment will only be reimbursed by Henner - GMC if the Medical Advisory Board has granted a prior agreement based on the information in this document, which must be completed by the Practitioner and sent by post, fax or email to:

**HENNER - GMC Medical Advisor - 10, rue Henner 75459 PARIS Cedex 09 - Fax: +33 1 40 82 43 85 - Email: [medical@henner.com](mailto:medical@henner.com)**

This form must be sent no later than 15 days prior to the date on which treatment is scheduled to begin.

Insured person's surname and first name: \_\_\_\_\_

HENNER - GMC ID No.: \_\_\_\_\_

Patient's surname and first name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Sex: \_\_\_\_\_

Is the current prior agreement application directly related to an accident ?

Yes

No

If so, please also attach a detailed report describing the circumstances of the accident.

**N.B.**

**The documents that must be submitted with this form are highlighted in blue.**

**In all cases (orthodontics / dental prostheses / periodontics / implantology),**

**Return this application and include a detailed cost estimate of the entire treatment**

### TO BE COMPLETED BY THE ATTENDING PRACTITIONER

#### ORTHODONTICS

If the application pertains to a mixed dentition intervention:

■ Does it concern a proscia rehabilitation (yes/no) ? \_\_\_\_\_ ■ Does it concern an early an interceptive orthodontic apparatus (yes/no) ? \_\_\_\_\_

Anticipated duration of the mixed dentition treatment (months): \_\_\_\_\_

If the therapeutic plan involves final dentition, indicate all of the following values:

■ **If the Ricketts analysis is used,**

**complete items R1-R2-R3-R4 + 5 to 11**

R1. Facial angle in degrees: \_\_\_\_\_

R2. HFI in degrees: \_\_\_\_\_

R3. Convexity in millimetres: \_\_\_\_\_

R4. DDM in millimetres: \_\_\_\_\_

5. Molar dental class with gap measured in millimetres: \_\_\_\_\_

6. Supra-occlusion or infra-occlusion measured in millimetres: \_\_\_\_\_

7. Dental arch contraction or dental arch expansion in relation to the number of teeth concerned: \_\_\_\_\_

No anomaly: \_\_\_\_\_ Isolated anomaly of a tooth: \_\_\_\_\_ Multiple anomalies: \_\_\_\_\_ Pathology of at least an entire area: \_\_\_\_\_

8. Lower incisor angle / NaPog in degrees: \_\_\_\_\_

9. Angle 11/41 or 21/31 in degrees: \_\_\_\_\_

10. Free margin distance 11/41 or 21/31 in millimetres: \_\_\_\_\_

11. Anticipated duration of the final dentition treatment (in months): \_\_\_\_\_

■ **If the Tweed analysis is used,**

**complete items T1-T2-T3-T4 + 5 to 11**

T1. FMIA in degrees: \_\_\_\_\_

T2. IMPA in degrees: \_\_\_\_\_

T3. ANB in degrees: \_\_\_\_\_

T4. Total DDM: \_\_\_\_\_

#### DENTAL PROSTHESES

Return this application and include the following documents and information:

Dental panoramic radiograph of more than 3 teeth and alveolar retrusion or RVG images after endodontic treatment or resumption of treatment

Devitalised tooth (teeth n°): \_\_\_\_\_ Vital tooth (teeth n°): \_\_\_\_\_

#### PERIODONTICS

Return this application and include the following documents and information:

Alveolar retrusion assessment (status) + Number of dental quadrants/area concerned + Diagnosis + Treatment plan

#### IMPLANTOLOGY

Return this application and include the following documents and information:

Dental panoramic radiograph + Implant area (number of teeth to be replaced by implants) +

Report including available bone height in implant area + Possible contraindications

Physician's seal and signature:

Date: \_\_\_\_\_

For medical information: +33 1 40 82 43 02

Patient's signature:

I hereby authorise my Physician to send the HENNER - GMC medical advisor all the medical information required for making a decision on my file.