

## PRIOR AGREEMENT APPLICATION

### DENTAL TREATMENTS



Major dental treatment will only be reimbursed by Henner 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:

Dentiste conseil de Henner - 14 boulevard du Général Leclerc, CS 20058, 92527 Neuilly-sur-Seine Cedex - FRANCE  
Fax : +33 (0)1 85 64 74 15 - Email : 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: ..... ID number: .....

Patient's surname and first name: .....

Date of birth: ..... Sex: .....

Is the current prior agreement application in direct relation with 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: .....

- 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: .....

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): .....

#### DENTAL PROSTHESES

Return this application and include the following documents and information:

Dental panoramic radiograph of more than 2 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 55 62 53 42

Patient's signature:

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