



PRIOR AGREEMENT APPLICATION - DENTAL TREATMENTS

Major dental treatment will be reimbursed by Henner only when they are the subject of a prior agreement by our Medical

Advisory Board, on the basis of this document, which must be completed by the Practitioner and sent by post to:

Henner Medical Advisor - 14 boulevard du Général Leclerc, CS 20058, 92527 Neuilly-sur-Seine Cedex - France - Fax: +33 1 85 64 74 15

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 yes, please attach to this document a detailed report describing the circumstances of the accident.

Note !

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 55 62 53 42

Patient's signature: _____

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