TO BE COMPLETED BY THE TREATING PRACTITIONER

MULTIPLE PROCEDURES AND PROSTHESES

Concerning the following procedures:
Type 1 Treatments:
Acupuncture, chemotherapy, dialysis, electrotherapy, physiotherapy, radiotherapy, physiotherapy, speech therapy, orthoptics, nursing care, medical prostheses (1).
Type 2 Treatments:
Psychiatric and psychotherapeutic treatments (only for treatments by a physician).
(1): Medical Prostheses: Attach the prescription

TYPE 1 TREATMENT

Medical Condition: ____

____

Procedures: ____

Number of procedures: ________ Total cost: __________ €

TYPE 2 TREATMENT

Description of clinical symptoms: ____

____

Diagnosis: ____

Medical History: ____

____

Family History: ____

____

Patient Personality: ____

Type of therapy planned: ____

Therapeutic Agreement: ____

Goal of therapy with expected results: ______________________________

____

Total number of sessions: __________ Frequency of sessions: ________________

Cost of each session: ___________ €

Date: ______ / ______ / 20____

Signature and stamp of Practitioner	Signature of Patient
	I hereby authorize my physician to provide the medical officer of MGEN IB all medical information needed to decide my case.

REQUEST FOR PRIOR AUTHORIZATION

Prosthetic treatments can only be reimbursed by **MGEN IB** in the event they received prior approval by the Medical Committee after review of this document. After completion by the Practitioner, this document must be mailed or faxed to:

ACI Gestion – B.P. 35 – 74270 - FRANGY - France
Tél : 33 4 50 88 10 09 - Fax : 33 4 50 02 05 65
Frais-de-sante@bil-assurances.fr

This form must be sent 15 days before the scheduled date for the start of treatment.

IMPORTANT:
The documents to accompany this application are shown in italics.
In all cases (Orthodontics - Dentures - Periodontics - Implants): return this application with a detailed estimate of the overall treatment.

INSURED PERSON

LAST NAME: ______________________________ FIRST NAME: ____________________

Identification number B.I.L : ____

Country where the health care was given: ____

Telephone: ________________________ Email: ______________________________

PATIENT (if the Patient was other than the Insured)

LAST NAME: ______________________________ FIRST NAME: ____________________

Date of birth: ______________________

Was the medical care following an accident?: ☐ YES ☐ NO
If yes, please attach to this document a detailed description of the circumstances of the accident..

I hereby certify that information in this claim for reimbursement is fully correct and truthful.

You are liable to termination of coverage, a fine and/or imprisonment if there is any fraud or misrepresentation (Articles L766-1-3, L114-13 of the Social Security Code and 441.1 of the Criminal Code).

Signature of insured:

TO BE COMPLETED BY THE TREATING PRACTITIONER

DENTAL TREATMENTS

ORTHODONTIA

If the claim is in the context of procedure for mixed (transitional) dentition:

Is it for rehabilitation therapy? ☐ YES ☐ NO

Is it for early interoceptive purpose? ☐ YES ☐ NO

Expected duration of mixed (transitional) dentition: ___________ month(s).

If the therapeutic plan includes permanent dentition treatment, please supply all the following data:

<u>If Ricketts' Analysis is used:</u>

R1 – Facial angle in degrees: _____________

R2 – FH in degrees: _____________

R3 – Convexity in millimeters: _____________

R4 – DDM in millimeters: _____________

<u>If Tweed's Analysis is used:</u>

T1 – FMIA in degrees: ___________

T2 – IMPA in degrees: ___________

T3 – ANB in degrees: ___________

T4 – DDM total: ___________

R5/T5 – Molar dental class with measured in millimeters: ___________

R6/T6 – Supraocclusion or infraocclusion measured in millimeters: ___________

R7/T7 – Dental arch contraction or dental arch expansion, relative to number of teeth involved:

No abnormality: ___________ Multiple abnormalities: ___________ Single abnormality of 1 tooth: ___________ Involvement of complete sector at least: ___________

R8/T8 – Inferior incisive angle / NaPong in degrees: ___________

R9/T9 – Angle 11/41 or 21/31 in degrees: ___________

R10/T10 – Distance free side 11/41 or 21/31 in millimeters: ___________

R11/T11 – Expected duration of treatment with final dentition (in months) ___________

DENTAL PROSTHESES

Return this application with the documents and the following information:

Panoramic dental image of greater than 3 teeth and retroalveolar images by Dental Digital Radiography (RVG), after initial treatment or resumption of endodontic treatment

Prosthesis for devitalized teeth (no. of teeth): ___________ Prosthesis for living teeth (no. of teeth): ___________

PERIODONTICS

Return this application with the documents and the following information:

Retroalveolar assessment (status) + number of quadrants involved +sector involved + diagnosis + treatment plan

IMPLANTOLOGY

Return this application with the documents and the following information:

Panoramic dental radiograph + implant site (No. of teeth to be replaced with implants) + report including the height of available bone at implant site + possible contraindications

Date: ______ / ______ / 20_____

Stamp and signature of heath practitioner	Signature of Patient
	I hereby authorize my physician to provide the medical officer of MGEN IB all medical information needed to decide my case.