# JSIS/RCAM – DENTISTRY (SINGLE FORM)

## TO BE COMPLETED BY THE JSIS MEMBER

Member's name: ..... Personnel/pension No: .....

Bill/estimate for: ☐ member of the scheme ☐ spouse/recognised partner ☐ dependent child (or person treated as)

- *To submit **a request for prior authorisation**, please send this form with the **'estimate' section** completed and the attachments requested to the Settlements Office.*
- *To submit a **request for reimbursement**, please send this form with the **'fees' section** completed, the invoice/receipt/certificate of treatment ('attestation de soins') and the requested attachments. In the case of top-up cover, please also attach the cost breakdown or letter of refusal issued by the primary scheme.*

***The JSIS will only undertake to provide reimbursement if all regulatory provisions are complied with.***
*More information: **https://myintracomm.ec.europa.eu/staff/en/health***

## TO BE COMPLETED BY THE PRACTITIONER

☐ **Cost estimate***
OR
☐ **Bill*** **for**: First name and surname: .....
Date of birth: .....

** Select one option*

| **PREVENTIVE CARE AND TREATMENT** | | Only use the relevant column | |
|---|---|---|---|
| **▼ Diagram: mark the teeth concerned for the entire treatment**<br>18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28<br>48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38 | Number(s) of tooth (teeth) per treatment | **ESTIMATE**<br>*To be completed only for treatments linked to prostheses or implants* | **FEES** |
| Consultation ..... | / | ..... | ..... |
| Intra-oral x-ray ..... | ..... | ..... | ..... |
| Panoramic x-ray, teleradiography, CBCT ..... | / | ..... | ..... |
| Fluoride treatment, sealing pits and fissures ..... | ..... | ..... | ..... |
| Descaling ..... | ..... | ..... | ..... |
| Filling ..... | ..... | ..... | ..... |
| Direct reconstruction, core build-up (with screw or tenon), resin inlays and facets..... | ..... | ..... | ..... |
| Devitalisation and root filling ..... | ..... | ..... | ..... |
| Normal extraction, incision of abscess, esquillectomy ..... | ..... | ..... | ..... |
| Surgical extraction, impacted tooth, apectomy, root amputation, frenectomy ..... | ..... | ..... | ..... |
| Other (please specify)..... | ..... | ..... | ..... |

| **PERIODONTAL TREATMENT** | | Only use the relevant column | |
|---|---|---|---|
| **▼ Diagram: mark the quadrants concerned for the entire treatment**<br>18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28<br>48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38<br>**▲ For an estimate: please attach a note setting out the treatment plan** | Quadrant(s) | **ESTIMATE** | **FEES** |
| Periodontal examinations (DPSI)..... | / | ..... | ..... |
| Root planing ..... | ..... | ..... | ..... |
| Surgery ..... | ..... | ..... | ..... |
| Moulded periodontal retainer..... | ..... | ..... | ..... |

| **DENTAL OCCLUSION** | Only use the relevant column | |
|---|---|---|
| **▲ For an estimate: please attach a note setting out the treatment plan** | **ESTIMATE** | **FEES** |
| Occlusal splint/night guard ..... | ..... | ..... |
| Mandibular advancement splint for OSAS ..... | ..... | ..... |

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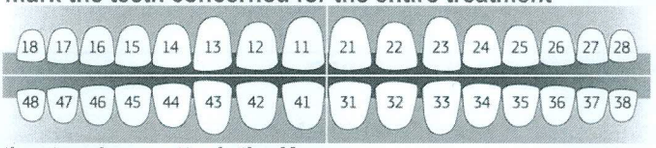
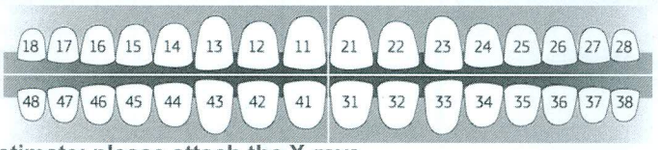
| PROSTHESES | | Only use the relevant column | |
|---|---|---|---|
| ▼ Diagram: mark the teeth concerned for the entire treatment<br>  <br><br>▲ For an estimate: please attach the X-rays | Number(s) of tooth (teeth) per treatment | ESTIMATE | FEES |
| • **FIXED PROSTHESES** | | | |
| Inlay core, gold, ceramic or resin inlay (indirect) ..... | ..... | ..... | ..... |
| Cast crown, telescopic crown, ceramo-metallic crown or element, ceramic or resin facet (indirect) ..... | ..... | ..... | ..... |
| Attachment (please specify) ..... | ..... | ..... | ..... |
| Temporary crown or pontic tooth (including fitting and removal) ..... | ..... | ..... | ..... |
| Removal or replacement of fixed elements, by element ..... | ..... | ..... | ..... |
| Repair of crowns or elements of bridgework, by element ..... | ..... | ..... | ..... |
| • **REMOVABLE PROSTHESES** | | | |
| Resin base plate ..... | ..... | ..... | ..... |
| Tooth or clasp on resin plate ..... | ..... | ..... | ..... |
| Complete upper or lower denture ..... | ..... | ..... | ..... |
| Temporary resin base plate ..... | ..... | ..... | ..... |
| Temporary tooth or clasp on resin plate ..... | ..... | ..... | ..... |
| Metal plate (including clasps) ..... | ..... | ..... | ..... |
| Tooth on metal plate ..... | ..... | ..... | ..... |
| Repair of a resin plate, addition (replacement) of one tooth or clasp on resin or metal plate. | ..... | ..... | ..... |
| Rebasing (partial or full/resin or metal plate) ..... | ..... | ..... | ..... |

| IMPLANTOLOGY | | Only use the relevant column | |
|---|---|---|---|
| ▼ Diagram: mark the teeth concerned for the entire treatment<br>  <br><br>▲ For an estimate: please attach the X-rays | Implant site(s) | ESTIMATE | FEES |
| Autogenous bone graft ..... | ..... | ..... | ..... |
| **Implant fitting** including preliminary study, implant, abutment, synthetic bone, membrane, disposable sterile material, local anaesthetics, surgical procedure, uncovering the head of the implant, pre-prosthetic gum surgery ..... | ..... | ..... | ..... |
| Other (please specify) ..... | ..... | ..... | ..... |

| ORTHODONTIC TREATMENT | Only use the relevant column | |
|---|---|---|
| ▲ For an estimate: please attach an explanatory note setting out the anomalies identified, the duration of the treatment and the treatment plan | ESTIMATE | FEES |
| Preliminary study/assessment models *to establish a diagnosis/treatment plan* ..... | / | ..... |
| X-rays/cephalometric analyses *to establish a diagnosis/treatment plan* ..... | / | ..... |
| **Fees for the treatment** including check-ups, upper/lower appliances and retainers, braces, additional cephalometric analyses/assessment models ..... | ..... | ..... |

| **Practitioner's stamp with phone number and country** (compulsory) | Total estimate: ..... *(specify currency and country)* |
|---|---|
| | Total fees: ..... *(specify currency and country)*<br>☐ I confirm that I carried out the care/treatment indicated above from ..... to ..... and have received the corresponding fees*.<br>☐ I attach the certificate of treatment ('attestation de soins')/receipt/invoice issued in accordance with national legislation*.<br>* **compulsory declaration** |
| Date: .....<br>Practitioner's signature: ..... | |