Easy-ER Application Form

Patient details

Member Number:	Member Surname:
Patient Date of birth: ccyy/mm/dd	Patient Name:

Practitioner's details

Practice Number:	Practice Name:
Email Address:	
Tel No:	

A brief description of the accident (please attach the accident report from the Emergency room, if applicable) & condition of the tooth/teeth in question.
Date of the accident: ccyy/mm/dd

Full proposed treatment plan (or attach quotes)

Date of Service	Qty	Tariff Code	Tooth No	ICD-10 Code	Amount

Please attach all supporting documents such as X-rays, photos, quotes, etc.
Email all the information to customercare@denis.co.za
Postal address: Private bag x1, Century City, 7446

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