



Practitioner Services

GP17(O) Form Completion

Guidance

Introduction

When should you complete a GP17(O)?

This form is used for claiming the following:

- Orthodontic diagnosis for treatment.
- Study Models for referral to a hospital Orthodontic Consultant for advice or treatment.
- Replacement of orthodontic appliances (Regulation 9).
- Repairs to appliances during treatment.
- Retention after completing active treatment.
- Orthodontic extractions.

It is not used for the routine monitoring of a “normally” developing occlusion or while observing developing third molars.

PART 1

NATIONAL HEALTH SERVICE SCOTLAND											
PART 1 TO BE COMPLETED BY THE DENTIST											
SURNAME	S	M	I	T	H						
FIRST FORENAME	J	O	H	N							
DOB	0	1	0	1	9	8	SEX(ENTER M or F)			M	
ADDRESS	BLOCK CAPITALS										
POSTCODE	Enter at all times										
Previous name if changed since last visit	If changed from last visit										

To be completed by the dentist.

When completing Part 1 of a GP17(O) make sure you:

- **Use BLACK INK & BLOCK CAPITALS**
- **Surname** – enter clearly as all details are manually input onto our system.
- **First Forename** - enter clearly as all details are manually input onto our system.
- **Date of birth** – enter only two boxes for the year of birth. The date of birth must not match the acceptance date.
- **Sex** - please enter **M** or **F**.
- **Address** – Enter the full address in **BLOCK CAPITALS**.
- **Postcode** - PSD encourage you to enter the patient's postcode as this is linked to the Deprived Areas Enhancement item of service uplift
- **Previous Surname** - this is completed when there has been a change of name from the last visit. For example marriage, deed poll etc. Confirm with new patients whether they have changed their name since their last visit to an NHS dentist, if so include the previous surname. This is entered on **one** occasion only.

PART 2

PART 2		GP 17(O) (Rev 10/08)
Dentist's Name, Address and List Number (Rubber Stamp)		Date of receipt for payment (For use by SDPB)
Dentist stamp including dentists name, address and list number.		For office use only
NHS Number	Patient's CHI number	

To complete Part 2 of the GP17(O), stamp the form with your dentist stamp so we have the details to process payment of your claim efficiently. Where possible include the CHI number at the NHS number part.

PART 3

A.
Completed
by patients
who are
liable to pay
for their NHS
treatment.

B.
Completed
by patients
who are
not liable
to pay for
their NHS
treatment.

PART 3 To be filled in by the patient. Please fill in and sign Part A or Part B. (If the patient is under 16 or cannot sign the form their parent, carer or other person responsible for them must sign.) I would like to have orthodontic treatment under the NHS. I understand that I may need to wear appliances. I am not having orthodontic treatment from another dentist under NHS. I agree to attend the Scottish Dental Reference Service if required.		To be completed by the dentist <table border="1"> <tr> <td colspan="2">Date of Acceptance for Treatment</td> <td rowspan="2">A</td> </tr> <tr> <td></td> <td></td> </tr> </table>		Date of Acceptance for Treatment		A							
Date of Acceptance for Treatment		A											
A. If you have to pay: 1. I promise to pay the dentist the charges, if any, prescribed by Regulations made under the NHS (Scotland) Act 1978. I understand that I may have to pay all of the charges before the treatment starts. 2. I may be able to get help with the charges because my income is low, in the meantime I understand I have to pay..... 3. I have, or am the partner of someone who has a current NHS charges certificate HC3 (Number) for partial help with NHS services. I have to pay the first £ of dental charges..... I am: <input type="checkbox"/> the patient <input type="checkbox"/> the patient's parent, guardian or carer (please give details below) Name (in BLOCK CAPITALS)..... Relationship to patient..... Signature..... Date.....		Tick boxes that apply <table border="1"> <tr> <td>C</td> <td>Treatment on referral</td> </tr> <tr> <td>D</td> <td>Number of Referral Claims</td> </tr> <tr> <td>E</td> <td></td> </tr> <tr> <td>F</td> <td></td> </tr> <tr> <td>G</td> <td></td> </tr> </table>		C	Treatment on referral	D	Number of Referral Claims	E		F		G	
C	Treatment on referral												
D	Number of Referral Claims												
E													
F													
G													
B. If you do not have to pay: I do not have to pay NHS dental charges because: 1. The patient is under 16 2. I am under 18 3. I am aged 18 and in full time education (give School/College and Town)..... 4. I am expecting a baby on (enter date in box)..... 5. I had a baby in the last 12 months (enter date in box)..... 6. I receive, or am in a family which currently receives, Income Support* 7. I am/my partner is entitled to, or named on, a tax credit exemption certificate 8. I/my partner receive(s) Pension Credit guarantee credit 9. I/my partner receive(s) Employment Support Allowance..... 10. I receive, or am in a family which currently receives, Income-based Jobseeker's Allowance* *The name of the person receiving the benefit/credit is..... 11. I have, or am the partner of someone who has a current NHS charges certificate HC2 (Number) for full help with NHS Services Proof can be given if necessary. I declare that the information I have given to the dentist is correct and complete. Warning: I understand that a deliberately false statement may lead to prosecution. I am: <input type="checkbox"/> the patient <input type="checkbox"/> the patient's parent, guardian or carer (please give details below) Name (in BLOCK CAPITALS)..... Relationship to patient..... Signature..... Date.....		<table border="1"> <tr> <td>M</td> <td></td> </tr> <tr> <td>N</td> <td></td> </tr> </table>		M		N							
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		<table border="1"> <tr> <td>Date of Approval (For Use by SDPB)</td> <td>O</td> </tr> </table>		Date of Approval (For Use by SDPB)	O								
Date of Approval (For Use by SDPB)	O												

The left side of Part 3 must be completed by the patient; if the patient is under 16, or cannot sign this part, a parent, carer or other responsible person must sign Part 3.

The right side of Part 3 must be completed by the dentist apart from "Box O" which is completed by Practitioner Services (PSD).

Part 4

PART 4 A. Prior Approval I have examined the patient and apply for the Board's approval to carry out the orthodontic treatment, which I consider necessary. Dentist's Signature..... Date.....	
PART 4 B. To the Dentist – Approval Granted Signed for the SDPB..... Date.....	

Part 4 A must be completed by the dentist if prior approval is required.

Part 4 B is completed by PSD if prior approval is granted.

PART 5

PART 5. To be signed by, or on behalf of, the patient after treatment As far as I know the treatment has been completed. I have paid, or undertake to pay, the total NHS charges for this course of treatment of..... £ (if you do not have to pay enter 00.00)	
Signature.....	Date.....

Part 5 must be completed by the patient after treatment; if the patient is under 16, or cannot sign this part, a parent, carer or other responsible person must sign Part 5. If the patient is not liable to pay for NHS treatment enter 0.00.

PART 6

PART 6. To be completed by the dentist. *Delete as applicable. *I have carried out all the necessary orthodontic treatment detailed and in my opinion the treatment has been satisfactory completed. *Retention, where appropriate is continuing. I claim payment of the fees due to me for the treatment specified.	
Dentist's Signature.....	Date.....

Part 6 must be completed by the dentist.

PART 7

PART 7 <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 10%;">E</td> <td style="width: 10%;">D</td> <td style="width: 10%;">C</td> <td style="width: 10%;">B</td> <td style="width: 10%;">A</td> <td style="width: 5%;"></td> </tr> <tr> <td>R</td> <td>8</td> <td>7</td> <td>6</td> <td>5</td> <td>4</td> <td>3</td> <td>2</td> <td>1</td> </tr> <tr> <td></td> <td>8</td> <td>7</td> <td>6</td> <td>5</td> <td>4</td> <td>3</td> <td>2</td> <td>1</td> </tr> <tr> <td></td> <td>E</td> <td>D</td> <td>C</td> <td>B</td> <td>A</td> <td></td> <td></td> <td></td> </tr> </table>		E	D	C	B	A		R	8	7	6	5	4	3	2	1		8	7	6	5	4	3	2	1		E	D	C	B	A				<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 10%;">A</td> <td style="width: 10%;">B</td> <td style="width: 10%;">C</td> <td style="width: 10%;">D</td> <td style="width: 10%;">E</td> <td style="width: 5%;"></td> </tr> <tr> <td></td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>6</td> <td>7</td> <td>8</td> <td style="width: 5%;">L</td> </tr> <tr> <td></td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>6</td> <td>7</td> <td>8</td> <td></td> </tr> <tr> <td></td> <td>A</td> <td>B</td> <td>C</td> <td>D</td> <td>E</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		A	B	C	D	E			1	2	3	4	5	6	7	8	L		1	2	3	4	5	6	7	8			A	B	C	D	E				
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Part 7 is for charting, strike out any teeth not present.

PART 8

PART 8A	Teeth			Poor
Radiological analysis	Unrupted	Absent	Supn.	Prognosis
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PART 8B				
Ceph analysis				
SNA.....°	1 1 Max	1 1 Mand		
SNB.....°	FMMM	APO	mm	

Part 8A must be completed if radiographs are claimed.

Part 8B must be completed if a Ceph is taken. No fee will be authorised for a Ceph unless an analysis is provided at Part 8B.

PART 9

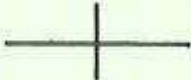

PART 9			
Assessment	1. Angles Class	2. Skeletal Class	
	<input type="checkbox"/>	<input type="checkbox"/>	
3. Overjet	Edge to edge	Negative	mm
4. Overbite	% Incomplete	Complete	
	<input type="checkbox"/>	<input type="checkbox"/>	
Open bite (Indicate teeth involved)		<input type="checkbox"/>	
5. Midline diastema	mm	6. Crossbite (Specify teeth)	<input type="checkbox"/>
	<input type="checkbox"/>		<input type="checkbox"/>
7. Centre lines (Relate to facial midline) (show by arrows any shift)	<input type="checkbox"/>		
8. Path of closure	centric	R	L
	Mandibular displacement	Forward	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth in premature contact	<input type="checkbox"/>		
9. Soft tissues/habits (Give relevant details)	10. Tooth/bone relationship (Enter teeth)		
	Spaced	Crowded	
	<input type="checkbox"/>	<input type="checkbox"/>	

Complete Part 9 for all 1(C)(iii) claims and as appropriate for Items 1(a) and 1(b).

Part 9 is used for assessment.

PART 10

PART 10 Treatment Proposals
Objectives

Extractions  Teeth to be banded/bonded 

Individual tooth movements

Correction of anterior occlusion

	Yes	No		
	<input type="checkbox"/>	<input type="checkbox"/>		

Correction of buccal occlusion

			Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	A/P		Laterally	

RRD B54896 1/08 (071412)

Part 10 is used for treatment proposals.
Complete this part as appropriate when claiming Items 1(a), 1(b) or 1(c)(iii).
State clearly the final objective of the proposed orthodontic treatment.

PART 11

PART 11 Relevant Medical/Dental/Orthodontic History

Part 11 - enter the patient's history here. This is necessary to assess their suitability and cooperation for treatment.

PART 12

PART 12 Oral Hygiene Status

Enter the patient's oral hygiene status. This is necessary to assess their suitability and cooperation for treatment.

PART 13

PART 13 Appliances					
	Yes	Number		Yes	Number
Removable	<input type="checkbox"/>	<input type="text"/>	U	Fixed	<input type="checkbox"/>
		<input type="text"/>			<input type="checkbox"/>
		L			L
	Type				
Functional	<input type="text"/>		Passive	<input type="checkbox"/>	<input type="text"/>
					<input type="text"/>
					U
					L
E.O.T.	Yes <input type="checkbox"/>	Retention	Fixed	U	Removable <input type="text"/>
					<input type="text"/>
					L
					U
					L

Part 13 must be completed indicating which appliances, if any, are to be used.

PART 14

PART 14 Repairs (State details)

Part 14 enter details of all repairs here.

PART 15

PART 15. Additional Information										
Additional Information										
Consultant Report	No		Yes		No.	£	p	R Items		
	a	b	c (1/2)							
Item 1										
Item 2b (model(s) set										
Item 2b (model(s) dupl.										
Rads	a	m	l	not	each					
Item 32 (a) 1										
Item 32 (a) 2										
Item 32 (a) 3										
Item 32 (a) 4										
Item 32 (a) 5										
E.O.T										
Item 32 (b) 1										
Item 32 (b) 1 additional										
Item 32 (b) 2 removable retainer										
Item 32 (b) 2 fixed/bonded retainer										
Item 32 (c)	1	2	3	4						
Item 32 (d) specify at Part 15										
Other - specify Part 15										
								T markers		
					V	£		2	9	

Additional information and claims for payment.

Indicate here if a Consultant report is available

Part 15 must be completed with any relevant additional observations.

Part 15 continued.

Consultant Report tick here whether or not a consultants report is available.

Item 1 Indicate appropriate Item 1 claim (examination).

Item 2(b) 1 set of initial and 1 set of final study models are required for all active treatment claims. Study models should be marked (labelled) clearly with the patient's name, date of birth, date of impressions and the practitioner's name and list number. They should be correctly bench trimmed and the occlusion clearly marked.

Rads (Item 2(a)) where appropriate radiographs should be claimed. If you do not claim for these PSD should be advised that they were available for diagnosis if not Item 32(a) fees cannot be authorised. Alternatively, a valid reason must be given for radiographs not having been taken.

Item 32(a) 1 for active appliances (removable spring and/or screw type).

Item 32(a) 2 for simple fixed appliances (fewer than 6 brackets or bands).

Item 32(a) 3 for a fixed appliance with more than 6 brackets or bands.

Item 32(a) 4 for functional appliances. This does not include cemented inclined bite planes, anterior bite planes or oral screens. Please note that the twin block fee is for a single functional appliance not two appliances.

Item 32(a) 5 for claiming a bite plane appliance. A bite plane incorporated in an active appliance is not a separate claim.

E.O.T for claiming if providing extra-oral traction. In addition, at this space, claim if a palatal arch or lingual arch is required as anchorage reinforcement. The fee is the same as E.O.T.

Item 32(b) 1 for claiming retention. Supervision of retention for a period of not less than five complete calendar months must be claimed on a separate GP17(O).

Item 32(b) 1 additional for claiming additional retention. Two additional periods of not less than two completed calendar months may be claimed. The patient should attend during each course of retention at least twice for the initial retention period and at least once for subsequent periods of retention, or at three-monthly intervals whichever is more frequent.

Item 32(b) 2 for claiming retainers. Retainers can only be claimed after active appliance treatment has been completed. PSD considers that a removable active appliance, made passive, is a satisfactory retainer. Pressure formed retainers that appear to require replacement over-frequently may not be "fit for the purpose" or "made of a suitable material".

Item 32(c) for claiming repairs. Repair claims should be submitted on a separate GP17(O) during the course of treatment and should relate to the Scale of Fees relevant to the acceptance date on the repair claim form.

Item 32(d) for claiming additions to or inclusions in orthodontic appliances.

Other – specify Part 15 for claiming other unspecified items including Item 32(e) replacement of appliances lost or damaged beyond repair or due to an act of omission on the patient's behalf.

Referral fees should be added to the claim total.

ADDITIONAL ADVICE

When a second opinion is requested, the Practitioner should have the patient's up-to-date study models and the appropriate radiographs available for the hospital Consultant.

If a Consultant's report is available, an Item 1(c)(iii) fee can only be claimed if Parts 7 to 13 are completed to our satisfaction.

Item 1(c)(iii) can only be authorised to the Practitioner undertaking the orthodontic treatment.

Orthodontic diagnosis claims must be entered on the same form as appliance therapy.

If Prior Approval is required, duplicate study models and appropriate radiographs must be submitted with the Prior Approval form.

If Prior Approval for a passive appliance is requested, for example, a space maintainer, or habit deterrent, 1 set of initial study models and 1 set of duplicate models may be claimed, (no fee is available for final study models). The duplicate initial models must be submitted with the Prior Approval form. Payment can be authorised when the appliance has been fitted.

If a hospital Consultant report is available, duplicate initial study models are not required, only the Consultant's report with the GP17(O).

If PSD requests the submission of study models, you may claim for duplicates of the models sent.

Please note PSD will only return models under exceptional circumstances.

Interim payment claims may be made when the first orthodontic appliance has been fitted. Interim payment fees include elements for diagnosis and fitting of the appliance. Only one interim payment will be paid per course of orthodontic

treatment. Please ensure the Interim Payment form is signed by the patient or person responsible for the patient and is attached to the GP17(O) before submitting for payment.

Referral fees should be claimed at the end of active orthodontic treatment. One referral fee is available for every three month period of treatment. These should be claimed on completion of active treatment. Subsequent claims for retention should have the appropriate number of referral visits claimed for those periods. These will be validated from the initial commencement date of active treatment. A maximum of 12 visits may be claimed for that patient.

Box C should be ticked with the number of referral claims entered in Box D and added to the total being claimed at Part 15.

Retention claims should be entered on a separate GP17(O) after appliance therapy has been completed. The GP17(O) for active treatment should be submitted for payment when retention commences. Where retention appliances are fitted, these may be claimed at this time on the "treatment" GP17(O).

Regulation 9 applications should be made to your Health Board for the patient's contribution to be assessed. When this has been received, please submit a separate GP17(O) together with the Health Boards decision regarding the patient's contribution.

ORTHODONTIC PRIOR APPROVAL BY VOLUME

Practitioners are advised that Prior Approval by volume, which relates to the value of treatment over £350.00, for appliance therapy, covers all courses of appliance therapy carried out by the same practitioner for the same patient.

This means if a practitioner has completed one course of appliance therapy, valued at £100.00 and wishes to undertake another, valued at £250.00, at a future date for the same patient, they are required to apply for Prior Approval for the second course of appliance therapy.

As a base-line PSD will be relating courses of appliance therapy commenced on or after 01.10.03.

The GP17(O) duplicate initial study models and any radiographs should be submitted when seeking Prior Approval in a case of this nature.

For cases involving orthodontic and other treatment, the other treatment will be considered separately from the orthodontic treatment for purposes of Prior Approval by volume and both forms should be submitted together to ensure the patient's contribution does not exceed the maximum charge.

DISCONTINUED CASES

A specially designed form SL/PSD 103 is available from our web site for these cases. This form facilitates the rapid processing of these claims. After completion, it should be forwarded with the GP17(O) for assessment of a modified fee. The patient's record card, relevant radiographs, photographs and study casts may be requested for examination by PSD.

You can access these forms by visiting:

www.psd.scot.nhs.uk/professionals/dental/prior-approval-forms.html

All completed cases must be submitted to PSD for payment within 3 months of the completion date of treatment to comply with current regulations as stated in the Statement of Dental Remuneration.