



Australian Government

Department of Health, Disability and Ageing

Guide to the Child Dental Benefits Schedule (CDBS)

Version 16

Effective October 2026



Important Information

This guide is for dental practitioners and explains the arrangements and requirements for the CDBS

This guide is not a legal document

In cases of discrepancy, the legislation will be the source document for the requirements of the program.

This guide is periodically updated. For the most current version of the guide please refer to the department's website:

www.health.gov.au/resources/publications/cdbbs-guide-to-the-child-dental-benefits-schedule

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What is the Child Dental Benefits Schedule?

The Child Dental Benefits Schedule (CDBS) is a program that funds basic dental services for eligible children. Funding is provided as a dental cap amount (the dental cap) over a relevant two calendar year period for each child.

Services that receive a benefit under the program include examinations, x-rays, cleaning, fissure sealing, fillings, root canals, extractions and partial dentures. The full list of services is available in the Dental Benefits Schedule and includes item numbers, descriptions, benefit amounts and applicable restrictions for each service.

Services can be provided in a public or private setting. However, benefits are not available for orthodontics, cosmetic dental work, or any services provided in a hospital.

Roles and responsibilities

Department of Health, Disability and Ageing

The Australian Government through the Department of Health, Disability and Ageing (the department), is responsible for the CDBS. The department monitors the CDBS program to meet legislation and policy objectives and maintain the CDBS program's integrity.

Services Australia

Services Australia is responsible for assessing a child's eligibility to receive dental benefits under the CDBS and manages the processing and payment of claims lodged for CDBS dental services. Services Australia also manages the application process for Medicare provider numbers for registered dental practitioners.

Dental providers

Dental providers render dental services to eligible dental patients under the CDBS.

Which children are eligible for dental services?

A child is eligible if they are:

- eligible for Medicare;
- aged 0-17 years at any point in the calendar year that the services are provided; and
- the child or parent/carer/legal guardian receive an eligible Australian government payment at any point in the calendar year that the services are provided.

Services Australia assesses a child's eligibility from the start of each calendar year and routinely identifies newly eligible children (eligible dental patients) using Medicare data. If a child is found to be eligible, a notification of eligibility will be sent to the child or their parent/guardian by post or electronically through myGov.

How long does eligibility last?

Once a child has been assessed as eligible, they are eligible for the entire calendar year (even if they turn 18 or stop receiving a relevant government payment). However, they must be eligible for Medicare on the day the service is provided.

How do I check if a patient is eligible?

You can check a child's eligibility online through [Health Professional Online Services](#) or by calling Services Australia on 132 150 (call charges may apply).

How does the Dental cap work?

The amount of dental benefits available to an eligible dental patient is capped over two consecutive calendar years. This maximum amount of dental benefits is known as the 'dental cap' and the two consecutive calendar years is known as the 'relevant two-year period'.

The relevant two-year period commences from the calendar year in which the eligible dental patient first receives a dental service under the CDBS. For example: if the eligible dental patient's first dental service is on 15 May 2025, the relevant two-year period will be the entire 2025 calendar year and, if the eligible dental patient is eligible the following year, the entire 2026 calendar year. If the eligible dental patient is eligible in 2027 or a later year, they will then have access to a new dental cap.

Scenario 1: If an eligible dental patient receives CDBS dental services and benefits to the value of \$550 in 2026, then in 2027 if they are still eligible for the CDBS they can receive further dental services and benefits to the value of \$608.

Scenario 2: If the eligible dental patient receives dental services totalling \$1,158 in 2026, they will reach the dental cap in the first year of the relevant two-year period. They will not be able to access further CDBS benefits in 2027 and must wait until 2028 to access a new dental cap, provided they are assessed as eligible by Services Australia.

Dental cap of \$1,158 for the 2026–2027 relevant dental cap two-year period.



2026	2027	2028
First year services are provided.	Second year where the patient can access any remaining balance if they are still eligible.	The patient will have access to a new dental cap starting from this year, if they are eligible.

Any balance remaining at the end of the relevant two-year period cannot be used to fund services that are provided outside that period. A new dental cap will become available if the relevant two-year period has lapsed and the child is assessed as eligible in the following year. An eligible dental patient's dental cap can only be used for eligible services provided to that patient. A patient's family members cannot share their CDBS entitlements.

What happens when the dental cap is reached?

Once a patient reaches their dental cap in the relevant two-year period, no further benefits are payable for the remainder of this period. This means that, where an eligible dental patient is charged for a dental service that would take the patient over the dental cap, only the amount of unused benefits will be paid for that dental service.

How do I check a patient's dental cap balance?

An eligible dental patient's dental cap balance can be checked online through [Health Professional Online Services](#) or by phoning Services Australia on 132 150 (call charges may apply). It is recommended you check the dental cap balance at each visit and advise of any out-of-pocket costs.

Dental practitioners - am I eligible to provide services under the CDBS?

You can provide services under the CDBS if you are a registered dental practitioner. This includes if you are a:

- dentist;
- dental hygienist;
- dental therapist;
- dental prosthetist; or
- oral health therapist.

The division you are registered in will determine whether you can directly claim for services you have provided, if you can claim for services provided by other dental practitioners, or if you can only provide services on behalf of a dentist.

Your scope of practice depends on your education, qualifications, training, experience and competence. You are expected to know your scope of practice and not provide services that exceed it.

Dental practitioners - am I eligible to directly claim for CDBS services that I have provided?

You are eligible to directly claim for CDBS services you have provided if you are a:

- dentist, or
- dental hygienist, dental therapist, or oral health therapist who is opting in to directly claim for services you provide; and
- have a Medicare provider number you are using to claim for CDBS services you have provided.

If you satisfy these criteria, you are referred to as a dental provider throughout this document.

Dental practitioners - am I eligible to claim for CDBS services provided by another dental practitioner?

If you are a dentist, you may claim for CDBS services provided on your behalf by a dental hygienist, dental therapist, dental prosthetist or oral health therapist.

All services provided under this arrangement must be performed in accordance with relevant state and territory law, conform to accepted dental practice and be provided under appropriate supervision or oversight.

Under this arrangement, the dentist is the dental provider, and claims can be submitted for services provided on their behalf using their Medicare provider number.

Specific arrangements for public sector dental practitioners

If you are a dental practitioner providing services in the public sector, you may provide services on behalf of a representative public dentist. Under this arrangement all services must be claimed under the Medicare provider number of the relevant representative public dentist.

For more information, you should contact the Department of Health in your state or territory.

Specific arrangements for dental hygienists, dental therapists and oral health therapists

From 1 July 2022, dental hygienists, dental therapists, and oral health therapists can opt-in to access Medicare provider numbers to directly claim for certain services under the CDBS. These services are listed in the Dental Benefits Schedule.

In addition, dental hygienists, dental therapists, dental prosthetists and oral health therapists are eligible to provide CDBS dental services on behalf of a dentist.

Specific arrangements for Dental Prosthetists

Dental prosthetists may only claim CDBS dental services provided on behalf of a dentist.

Dental practitioners - how do I apply for a Medicare provider number?

To claim for services, dental providers need to have a Medicare provider number linked to the location where the CDBS services will be provided.

Eligible dental practitioners apply for an initial Medicare provider number by [completing the HW093 form](#) and returning the form to Services Australia. Subsequent Medicare provider numbers can be applied for through [Health Professional Online Services](#) portal.

Services Australia will send you a letter with your provider numbers for each of your new practice locations. You need this letter before you can provide CDBS dental services. You can also manage your provider numbers, practice details and locations through the Health Professional Online Services portal.

There are specific claiming arrangements for dental practitioners who work in public dental clinics. Information on those arrangements can be obtained from state and territory government dental services.

What dental services are covered by the CDBS?

The CDBS provides benefits for a range of basic dental services.

Each dental service that can receive a benefit has its own item number. These items and associated descriptors, restrictions and benefits are set out in the Dental Benefits Schedule.

The Dental Benefits Schedule is based on the Australian Dental Association Australian Schedule of Dental Services and Glossary, 13th Edition. The CDBS dental items use an additional two-digit prefix of 88. For example, the CDBS item 88011 corresponds to Australian Dental Association item 011.

There are some differences between the Dental Benefits Schedule and the Australian Dental Association Schedule.

You must read the Dental Benefits Schedule carefully before providing CDBS dental services to ensure you use the correct item number that coincides with the service you have provided and that you understand any restrictions or limitations that apply to providing that service.

Clinically relevant services

The *Dental Benefits Act 2008* requires that for a dental benefit to be payable a service must be 'clinically relevant'. A 'clinically relevant' service means a service that is generally accepted in the dental profession as being necessary for the appropriate care or treatment of the eligible dental patient to whom it is rendered.

Hospital services

Dental benefits are not payable where the eligible dental patient receives dental services in a hospital.

Limits on individual services

Many of the dental items have specific limitations or rules unique to the CDBS, for example, frequency of the service, linkages between items, restrictions on who can claim for the dental service and other conditions on claiming.

Limits and rules are set out in the individual item descriptors in the Dental Benefits Schedule.

Dental practitioner - do I have to quote for services?

It is important that an eligible dental patient or the parent/carer/guardian are informed of the likely costs so they can plan for any out-of-pocket expenses.

If you wish to participate in the CDBS it is a requirement of the program that you inform the eligible dental patient or the parent/carer/guardian of the proposed costs of treatment as well as the dental practice's billing arrangements.

Prior to performing any services, you must have a discussion with the eligible dental patient or the parent/carer/guardian about:

- the proposed treatment.
- the likely treatment costs, including out-of-pocket costs; and
- the billing arrangements of the practice (i.e. bulk billed).

Informed Consent

Before any dental treatment is provided, you must inform the eligible dental patient or the parent/carer/guardian of the proposed treatment and associated costs

Obtaining Written Consent

Once the eligible dental patient or the parent/carer/guardian has been fully informed, you must obtain written consent using the approved Bulk Billing or Non-Bulk Billing Child Dental Benefits Schedule – Patient Consent Form – [Child Dental Benefits Schedule – Bulk Billing and Non-Bulk Billing Patient Consent Forms](#) This documentation is a legal requirement and must be retained as part of the eligible dental patient's dental record.

Frequency of Consent Requirement

- Bulk-Billing patient consent form – must be signed during the first visit of each calendar year.
- Non-Bulk Billing patient consent form – must be signed on each day on which a dental service is provided to the eligible dental patient.

Dental practitioner – deciding what to charge (how to charge, billing and claiming for services)

Like providers under Medicare, private dental providers are free to set their own fees for services.

If you directly charge the eligible dental patient an amount above the CDBS dental benefit for a dental service or the dental cap is exceeded, the additional charges must be met by the eligible dental patient or the parent/carer/guardian.

Bulk billing

In the case of bulk billing, you accept the relevant CDBS benefit as full payment for the service.

You cannot charge the eligible dental patient a co-payment of any kind for a bulk billed dental service.

Eligible Dental Patient claim

At the end of a visit, you can request the eligible dental patient to pay in full for the services provided. You will need to provide the eligible dental patient with an itemised account/receipt containing all of the necessary details so that they can claim the benefit from Medicare.

Your eligible dental patient can then claim the benefit from Services Australia.

Pay Doctor Via Claimant (PDVC)

At the end of a visit, you can provide the eligible dental patient with an itemised account (invoice) for the services provided.

In this case, the eligible dental patient does not pay for the service at the time of the visit. Instead, the eligible dental patient takes or sends the unpaid account to Medicare for a benefits cheque to be issued in your name (for the total benefit payable to the eligible dental patient for the service).

It is then the eligible dental patient's responsibility to provide the Medicare cheque to you and pay the balance of the account, if any. When the eligible dental patient presents your cheque and any balance, you should indicate on the receipt that a 'Medicare cheque for \$.... was included in the payment of the account'.

The PDVC payment method will cease by 30 June 2028 as part of a whole-of-government decision to phase out cheque payments.

How to lodge a claim

Electronic claiming

Dental providers can lodge claims electronically with Services Australia.

Services Australia offers a choice of:

- Medicare Online; and
- Medicare Easyclaim.

To discuss electronic claiming options that would suit your practice, you can contact the eBusiness Service Line on free call 1800 700 199 (calls from mobile phones may be charged at a higher rate). The eBusiness Service Line is available Monday to Friday, between 8.00 am and 5.00 pm, Australian Eastern Standard Time.

More information about the different types of online claiming and the benefits is available at the Services Australia website [CDBS for health professionals – Claiming – Services Australia](#)

Manual claiming

If you are unable to submit an electronic claim, approved bulk billing/Medicare claim forms can be ordered using the [Medicare stationery order form \(DB6Ba\)](#).

It is recommended that you submit manual claims as soon as possible after the patient visit.

What information must be included in billing/claiming for services?

There are requirements on the information that needs to be on the account or receipt in order for the claim to be paid. A valid account or receipt needs to include:

- The eligible dental patient's name;
- The eligible dental patient's Medicare number;
- The date of service;
- The item number in the Dental Benefits Schedule that corresponds to the service;
- The dental provider's name and provider number; and
- The amount charged in respect of the service, total amount paid and any amount outstanding in relation to the service.

For bulk billed services, a Medicare approved bulk billing form must be used. The form requires:

- The eligible dental patient's name;
- The date of service;
- The item number in the Dental Benefits Schedule that corresponds to the service;
- The dental provider's name and provider number; and
- The amount of the dental benefit being assigned to the dental provider.

Record Keeping

Dental providers must maintain adequate records for four years from the date of service including:

- Bulk-Billing and Non-Bulk Billing patient consent form(s).
- Clinical notes including details of the particular tooth or teeth a CDBS dental service relates to, where relevant,
- Any other relevant document/s such as itemised accounts or receipts verifying the dental service(s) claimed were provided.

What billing/claiming practices are not permitted?

You cannot bill/claim before services are provided

Under the CDBS, eligible dental patients cannot be charged for a service until it has been provided. That is, dental providers cannot charge eligible dental patients for services that are identified as needed later but have not yet been provided. This includes taking a deposit for a proposed service.

For example, a benefit for dentures cannot be claimed until the dentures have been provided to the eligible dental patient.

You cannot bill/claim for services that are not clinically relevant

The CDBS cannot pay benefits for a service that is not 'clinically relevant'. 'Clinically relevant' means a dental service that is generally accepted in the dental profession as being necessary for the appropriate care or treatment of the eligible dental patient to whom it is rendered. If a dental practitioner chooses to use a procedure that is not generally accepted in their profession as necessary for the treatment of the eligible dental patient, the cost of this procedure cannot be included in the fee for a CDBS item.

Treatment that is predominantly for the improvement of the appearance of the eligible dental patient (i.e. cosmetic) is not considered clinically relevant and cannot be claimed.

You cannot substitute items

The account you issue to an eligible dental patient must accurately reflect the dental services provided.

The CDBS only covers basic dental care. Dental services that are not part of the Dental Benefits Schedule and not eligible for a benefit cannot be claimed under the CDBS. Eligible dental patients may pay for ineligible services privately, including with the assistance of private health insurance.

Consequences of non-compliance

Where a benefit for a CDBS dental service has been incorrectly paid, the Department of Health, Disability and Ageing may request recovery of that benefit from the dental practitioner concerned. Beyond the recovery of benefits, making or authorising false or misleading statements relating to dental benefits is an offence, and penalties including fines and imprisonment may apply.

Can private health insurance be used for CDBS dental services?

Eligible dental patients with private health insurance covering dental services **cannot** claim a benefit from both the private health insurer and the CDBS for the same dental service. Eligible dental patient cannot use private health insurance to 'top up' the CDBS benefit they have received for a dental service. Private health insurance can be used for any dental services not provided under the program, but these items must be billed separately.

Where do I get more information?

For further information visit the [Services Australia website](#) or phone Services Australia on 132 150 (call charges may apply).

Glossary

Term	Definition
CDBS	Child Dental Benefits Schedule
Child Dental Benefits Schedule - Bulk Billing Patient Consent Forms	Department of Health, Disability and Ageing approved consent form.
Child Dental Benefits Schedule Non-Bulk Billing Patient Consent Forms	Department of Health, Disability and Ageing approved consent form.
Dental provider	A person who is a dental provider in relation to a dental service with an assigned Medicare provider number and directly bills for dental services under the CDBS: (a) dental hygienists; (b) dental therapists; and (c) oral health therapists.
Dental Hygienist	Means a person who has general registration in the dental hygienist division of the dental profession under a law of a State or Territory.
Dental Prosthetist	Means a person who has general registration in the dental prosthetist division of the dental profession under a law of a State or Territory.
Dental Therapist	Means a person who has general registration in the dental therapist division of the dental profession under a law of a State or Territory
Department	Department of Health, Disability and Ageing
Eligible Dental Patient	A person who is aged under 18 years at any time during the calendar year and who, or whose parent, carer or guardian, receives an eligible Australian Government payment, such as Family Tax Benefit Part A, at any time during that year. The person must also be eligible for Medicare on the day the dental service is provided.
Oral Health Therapist	Means a person who has general registration in the oral health therapist division of the dental profession under a law of a State or Territory.
Private dental clinic	A clinic that is not funded or operated by state or territory governments

Provider number	As the same meaning as in the Health Insurance Regulations 2018
Public Sector provider	A dental provider employed by, contracted to, or providing dental services under an arrangement with: (i) the Commonwealth; or (ii) a State; or (iii) a Territory; or (iv) a local governing body; or (v) an authority established by a law of the Commonwealth, a law of a State or a law of a Territory;
Registered Dental Practitioner	Means a dental practitioner who has general registration, or specialist registration, in the dentist division of the dental profession under a law of a State or Territory.

Health.gov.au

All information in this publication is correct as at October 2026

