WCB Workers Compensation Board of Manitoba

Phone 204-954-4922
(Toll free 1-855-954-4321)
333 Broadway, Winnipeg R3C 4W3
wcb.mb.ca

Dentist Report

Claim Number	35

We understand you may be visiting a dentist for treatment as a result of an injury that occurred at work. If so, please forward this form to the dentist for completion and return it to the Workers Compensation Board of Manitoba.

Worker Name & Address

Worker Name		
Worker Address		
City	Province	Postal Code

Worker Information

Gender	Date of Birth (DD/MM/YYYY)	Phone Number

Employer Information

Employer's Name		Employer's Address
City	Province	Postal Code
Firm Number		Telephone Number

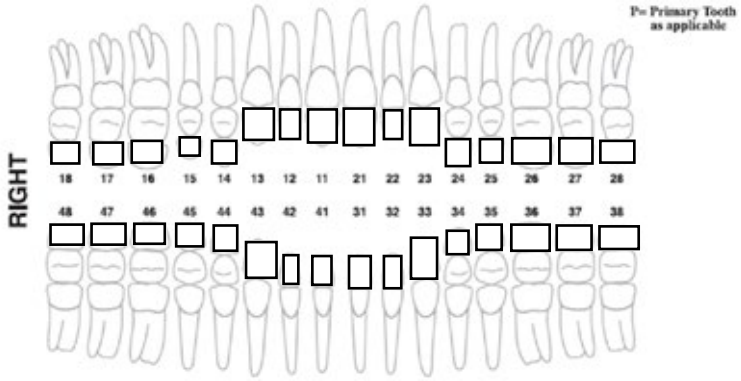
Injury Details

Date of Injury	Area(s) of Injury

Check Report Type That Applies ☐ 1. Initial ☐ 2. Change in treatment ☐ 3. WCB re-treatment	Examination Date (dd/mm/yyyy)

Dental Charting

1. For Initial Report: draw in ALL previous dental treatment & pre-existing missing teeth, caries & chipped teeth.
2. For Change in Treatment: draw in change of treatment.
3. For WCB re-treatment: draw in Treatment failure due to WCB-related dental treatment.



4. Oral Hygiene **Pre-Accident** Good ◯ Fair ◯ Neglected ◯ Unknown ◯ **Active Periodontal Disease** Yes ◯ No ◯ Unknown ◯ If yes, provide a copy of periodontal charting. **Smoker** ◯ **Non-Smoker** ◯ If smoker, average per day: _____	**5. Diagnosis: (Dentist Only)** Please indicate condition resulting from the workplace accident. A. Tooth structure only ☐ B. Previously restored portion of the tooth (eg. filling, crown, bridge, denture, implant) only. ☐ C. Both A and B ☐
6. Mechanism Of Injury How did the dental injury occur as a result of the workplace accident? Report all damage, paying attention to extent and surface location.	**7. TMJ** Not Applicable ☐ Applicable ☐ Jaw Opening: _____(mm) between free edges of the upper and lower incisors Protrusion: _____ Laterotrusion: Right _____ (mm) Left _____ (mm) Prior TMJ Treatment: Yes Date: _____ Type:_____ No

Fax this form - in Winnipeg: 204-954-4999 | toll free: 1-877-872-3804

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8. Enclosures

Radiographs conventional/digital Most current ☐ Post ☐
Trimmed Casts Most current ☐ Post ☐
Photographs conventional/digital Most current ☐ Post ☐
If referring to denturist: Oral Health Certificate is required for complete dentures. Yes ☐
Prescription for partial dentures is required. Yes ☐

When submitting your correspondence ensure tooth numbers, dates, worker's name, and dentist name are labeled on all enclosures.

Treatment Provided to Date:

Date Service Performed	Tooth Number	Procedure Code	M.D.A. Fee Recommended Fee Guide	Please Separate: L = Lab Charges E = Expense Fees	Potential Future Treatment (Will require pre-approval)	Prognosis 2-3 Years 4-6 Years 8-10 Years > 10 Years
			$			
			$			
			$			
			$			
			$			

***Forward Copies Of Itemized Dental Lab Charges And Expense Fees**

Proposed Future Treatment:

Date Service Performed	Tooth Number	Procedure Code	M.D.A. Fee Recommended Fee Guide	Please Separate: L = Lab Charges E = Expense Fees	Potential Future Treatment (Will require pre-approval)	Prognosis 2-3 Years 4-6 Years 8-10 Years > 10 Years
			$			
			$			
			$			
			$			
			$			

***Forward Copies Of Itemized Dental Lab Charges And Expense Fees**

Regular maintenance of dental health and rehabilitation is the worker's responsibility and lack thereof is not eligible for WCB dental benefits.

Declaration:

To be completed by the Dentist.

I, (print surname and first name) _____, hereby certify

a) That the dental injuries specified in this report result from a workplace injury or are consistent therewith.

b) That the proposed treatment is solely to restore the damage sustained in the workplace incident or re-treatment failure.

c) That the type of treatment is consistent with the patient's pre-accident status and standard of dental care.

d) That I am providing services within my scope of practice and training.

Stamp or type name and address of dentist or group:	**Signature of Dentist**	
	Date (dd/mm/yyyy)	Telephone Number