Halifax Office
5668 South Street
PO Box 1150
Halifax, NS B3J 2Y2
1-800-870-3331 toll free
902-491-8999 local
902-491-8001 fax

Sydney Office
336 King's Road, Suite 117
Medical Arts Building
Sydney, NS B1S 1A9
1-800-880-0003 toll free
902-563-2444 local
902-563-0512 fax

Dental Claim

Form 122:10/2002

Claim Number

Date of Accident

To be completed by the Dental Surgeon. Please print clearly.

Dentist's Name

Address

City Province Postal Code

Telephone Facsimile Email

For Dentist's Use Only – Additional information, diagnosis, procedures, or special consideration. Attach additional narrative report, if appropriate.

Patient's Name

Address

City Province Postal Code

Telephone Facsimile Email

Employer's Name

Please circle any natural teeth completely lost by the accident. Use a straight line to show parts of any natural teeth broken by the accident. Use an "x" to show any artificial or crowned teeth injured by the accident. If plate or bridge work damaged, please specify.

UPPER — Labial — Right: 18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28 :Left

LOWER — Labial — Right: 48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38 :Left

Date of Service (DD MM YYYY)	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fee	Estimated Laboratory Charge	Actual Laboratory Charge	Work Completed Yes No	Fee for Work Completed At Time of Billing*	WCB Fee Code Approved Yes No

***All Dental Claim forms must be accompanied by appropriate diagnostic aids (e.g., x-rays, photos, models, other).**

Total Fee Submitted

- Describe the present condition of each natural tooth injured and, if known, its condition before the accident.

- How many teeth injured in the accident have actually been knocked out or extracted? ______
- Were the injured teeth natural or artificial? ______
- If artificial, were they removable or permanently fixed? ______

Dentist's Signature

Date

Patient's Signature

Date

To the Dental Surgeon - Instructions for submitting this claim.

1. All examinations or work must be begun, and this form returned to the WCB, as soon as possible following the accident.
2. The WCB is not responsible for replacement of dentures or bridges damaged by the accident, fixed or otherwise, without prior authorization from the WCB.
3. The WCB is responsible for extraction, repair or replacement of the injured teeth, if the injured or lost teeth were in a satisfactory state of preservation prior to the injury, so as to ensure usefulness to the client for a reasonable period of time.
4. Where one or more teeth are lost or have been extracted, and it is thought advisable on account of their condition that all other teeth in the jaw should be extracted, the WCB is only responsible for the cost of a partial plate. The Dental Surgeon, if he/she wishes to fit the client with a full plate, should notify the client that the client is responsible for any additional cost above that allowed by the WCB for a partial plate.
5. The WCB reimburses the Dental Surgeon at the rate indicated by the Nova Scotia Dental Association as set out in the "suggested fee guides" for dental services, general practice or specialty, as applies.
6. Please return this form to the WCB immediately after you have completed your examination.

Please call the WCB if you have any questions at 1-800-870-3331 or 1-800-880-0003.

WCB Authorization Signature

Date