July 2016

WorkplaceNL

SEND BY FAX ONLY	CONTACT US AT:	VISIT US AT:
f 709.738.1479	t 709.778.1000	workplacenl.ca
f 1.866.553.5119	t 1.800.563.9000	

NOTE: THIS FORM IS TO BE FAXED ONLY

CLAIM NUMBER	Form 96
WorkplaceNL BILLING NUMBER	

☐ **DENTIST'S FINAL REPORT AND ACCOUNT** ☐ **DENTIST'S RECURRENCE REPORT AND ACCOUNT**

(*Please check one box*)

Accounts should be submitted within thirty days of completion of treatment to WorkplaceNL.

DENTIST'S NAME			WORKER'S - SURNAME
ADDRESS			GIVEN NAMES
CITY OR TOWN	PROV.	POSTAL CODE	ADDRESS
TELEPHONE NO.	FAX NO.		CITY OR TOWN / PROV. / POSTAL CODE
DATE OF INJURY			DATE OF BIRTH (YY MM DD) / PATIENT'S MCP NUMBER

Has Dental Treatment been completed? YES ☐ NO ☐ Date Treatment Completed? ______ YY MM DD

CODE: **O** - Office **H** - Hospital **C**- Consultation **X** - X-Ray **A** - Anaesthetic **Z** - Operation

Please show in the spaces below the date of consultations or treatments:

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

PROCEDURE	Schedule Number	No. of Serv.	Amount	**WorkplaceNL USE ONLY**
Consultation Fee (Payable only when consultation is authorized by WorkplaceNL)				
Examination and Report Form 67 or equivalent				
Extractions (Tooth No. Int. Code)				
Fillings (Tooth No. Int. Code)				
Crowns (Tooth No. Int. Code)				
Bridge (Tooth No. Int. Code)				
Dentures (Tooth No. Int. Code)				
X-Ray				
Anaesthetic - Type and duration detail below				
Operation (Tooth No. Int. Code)				
Other Treatment - detail below				
TOTAL				

NOTE: *Please quote FEE ITEM CODE as shown in the Fee Guide.*

REMARKS:

I declare that the above is a correct statement of service personally rendered by me, and that the fees are not more than would be properly and reasonably charged if the worker were paying the account.

Signed this __________ day of ______________________ , 20___ at ________________________________ , NL

Stamp or type name and address of Dentist or group and personally sign.

Phone No: ________________________ Signature of Attending Dentist ________________________________