SEND BY FAX ONLY
f 709.738.1479
f 1.866.553.5119

CONTACT US AT:
t 709.778.1000
t 1.800.563.9000

VISIT US AT:
workplacenl.ca

NOTE: THIS FORM IS TO BE FAXED ONLY

July 2016

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.

EMPLOYER'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 ______________