Claim No.	Desk	Alloc. No.					
Worker's Name							
Injury							
Date of Injury							
To Enquire, Contact							
For toll free number, check local directory							
Date of First Treatment							

Important information about completing this form is on the back. Please carefully read the instructions listed on the back.

Pre Accident History

Appraise and describe the condition of the teeth before the accident.

Patient's Right

Patient's Right

Patient's Right

Patient's Right

Patient's Right

Patient's Right

Patient's Left

Indicate any fixed bridgework present. Specify abutment teeth and type of abutment attached.

Indicate any fixed bridgework present and type of abutment attached.

Indicate any teeth with crowns.

Indicate any teeth missing before the accident.

Indicate any tieth missing before the accident.

Indicate any tieth missing before the accident.

Forward radiographic films of diagnostic quality of injured areas along with your comments.

Describe injuries to the teeth and mouth as a result of the accident.

Indicate teeth damaged or missing as a result of this accident.

Indicate extent and location of fracture where present and comment.

If teeth were artificial did you see fractured bridge or dentures. Describe extent of damage in detail.

Give details of any other oral injury.

0278A (01/05)

PRE-DETERMINATION

Date of Service		Procedure Codes (ODA)			Initial Tooth Code	Tooth Surface	Dentist's Fee		Laboratory Charge		Total Charges			
aa	mm	уу												
									\$		\$		\$	

Additional Comments: (use additional sheet if necessary)

Do you wish WSIB dental consultant to phone?			
yes			
Mounted x-rays enclosed: yes no (if not enclosed gives)	ve reasons)		
(If duplicate x-rays are submitted, please identify (R) or (L). Bite wing x-rays	s are not acceptable.)		
Dentist's Name (please print)		Area code	Phone No.
	Special	ist	·
Postal Address		•	Date
City or Town	Postal Code	Dentist's Signature	

Please Note: Read the following instructions carefully before completing this form.

- 1. Complete this form in detail and return it to your local Workplace Safety and Insurance Board (WSIB) office.
- 2. Please PRINT legibly in black ink or type your comments/recommendations.
- 3. Attach pre-treatment x-rays.
- 4. Prior authorization must be obtained from the WSIB for all treatment except for x-rays and emergency services.
- 5. If the patient has entitlement for dental treatment, emergency services will be paid.
- 6. Describe in detail all emergency treatment rendered by you to date. Include ODA procedure code(s), tooth number, tooth surfaces and fees.
- 7. Copies of laboratory invoices should accompany all billings.
- 8. Dental services are paid in accordance to fees approved by the WSIB. The patient or any other insurer is NOT responsible for any balance over and above these fees.
- 9. A fractured incisor is a common accidental injury. In case of a vital tooth, it is requested that if necessary a provisional crown be placed to permit the tooth to recover from traumatic shock. The final crown restoration to be delayed for 3 months from date of accident.