MOHAWK SELF INSURANCE

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Dentist's Report

Part 1 - Dentist

Worker Name :____________________________________ **DENTIST Name :**____________________________________

Address :____ **Address :**____

Telephone :_______________________________________ **Telephone :**_______________________________________

Employer Name :____

Telephone :_______________________________________ **Telephone :**_______________________________________

Date of service (D / M / Y)	Procedure code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fees	Laboratory Charges	Total Charges

This is an accurate statement of services performed. Total fee due and Submitted: $___________

Part 2 – Dentist's Supplementary Report

1. Description of damage____

2. Is further treatment indicated? Yes______ No_____ If Yes, please indicate:
   Int. Tooth Code Treatment indicated – use procedure code if possible Estimated Date of treatment (D/M/Y)

____

____

3. Describe further potential problems and indicate time frame:____

____

4. A) How many teeth were injured? ________ B) Were these whole or sound teeth?
   C) How many of these teeth had fillings?_________ D) How many of these injured teeth had crowns?_________
   E) How many of these injured teeth had root canal treatment?__________
   F) If not whole or sound teeth, explain why____

Dentist's Signature____ **Date** __________________________________

Part 3 – Dental Accident Supplementary Questionnaire for covered claimant

Date of accident D________M________Y________ Time of accident? ________ a.m./ p.m.

Where did the accident occur? ____

Describe how accident occurred? ____

Nature of Injury? ____

If taken to hospital, name of hospital? ____

Date admitted D________M________Y________ Time ________ a.m. / p.m.

Date discharged D________M________Y________ Time ________ a.m. / p.m.

Dentist's Name ____

Part 4 – Employee / Patient Information

Patient____ Date of Birth D________M________Y________

Do you have coverage for dental expenses under any of the following?

Group Health Plan? Y_____N____Name of insuring agency or plan/Policy No.____________________________

Group Dental Plan? Y_____N____Name of insuring agency or plan/Policy No.____________________________

CSST Plan? Y_____N____ Name of insuring agency or plan/Policy No.____________________________

Government plan? Y_____N____ Name of insuring agency or plan/Policy No.____________________________

I certify that to the best of my knowledge that the statements made above are true, correct and complete

Signature of WORKER________________________________ Date D________M________Y_______

Part 5 – Employer (for completion only if applicable)

Date coverage commenced? D________M________Y_____ Date terminated D________M________Y_______

Program Administration ____

Address ____

Signature of Employer ______________________________________ Print Name ______________________

Position / Title _______________________ Date D________M________Y________ Telephone No.____________

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment. I acknowledge that the total fee of $____________ is accurate and has been charged to me for services rendered. I authorize release of the information contained in this claim form to my insuring program administrator.

Worker Signature__________________ Date D________M________Y________