DENTURIST GUIDE

C-617 REV June 2006

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WORKERS' COMPENSATION BOARD

PREAMBLE

The following information is provided to assist denturists treating workers for injuries covered by the Workers' Compensation Act (WCA) of Alberta.

The WCA defines physician as "a person licensed to practice any of the healing arts in Alberta". Therefore, for the purposes of the WCA, the term “physician” refers not only to physicians but also includes other health care providers such as denturists. The WCA also gives the Board legislative authority to determine all questions as to the necessity, character and sufficiency and the amount payable in respect of any medical aid (such as dental services) provided to a worker who suffers an accident (Section 81 of the WCA). Further, no part of the cost of any medical is payable by a worker (Section 86 of the WCA).

Below are paraphrased excerpts from the WCA, which pertain to the provision of dental care to injured workers.7

Section 34(1)

A physician (*denturist*) who attends an injured worker shall:

(a) forward a report to the Board within two business days of the first attendance on the worker; and

(b) at any time requested by the Board

Section 78(1)

The Board may:

(a) provide medical aid (*which includes dental services*) to a worker who suffers an accident, or

(b) pay for the cost of medical aid (*dental services*) provided to a worker who suffers an accident.

Section 78(2)

If any apparatus or appliance, or the cost of any apparatus or appliance, is provided by the Board pursuant to subsection (1) the Board shall also provide for or pay for the cost of the repair, maintenance and replacement of that apparatus or appliance if it is in need of repair, maintenance or replacement by reason of accident or ordinary wear and tear and if the disability in respect of which the apparatus or appliance was provided continues.

Section 79

The Board may assume the cost of replacement or repair of articles of clothing, dentures, eye-glasses, artificial eyes or limbs or hearing aids that are lost, damaged or destroyed as a result of an accident, regardless of the date of the accident.

Section 80(1)

The Board shall determine all questions as to the necessity, character and sufficiency of, and the amount payable in respect of, any medical aid provided to a worker who suffers an accident.

Section 84

If medical aid is to be provided to a worker the Board may, if it considers it appropriate, permit the worker to select the physician (*denturist*) of his choice.

Section 86

No part of the cost of any medical aid provided to or in respect of a worker is payable by the worker (*no additional fees are payable by the worker*).

GENERAL GUIDELINES FOR PROVIDING DENTURIST SERVICES

1. All denturist services, other than the examination, the proposed treatment plan and emergency treatment (for the relief of pain), must be authorized before treatment is commenced. The Denturist Report must be completed after the first examination, along with a cost breakdown of the proposed treatment. The Denturist Report and cost breakdown must be submitted to the Board, preferably by fax, within two business days of the initial examinations. For more comprehensive or difficult cases a second report must be sent within ten days.

2. The WCB responsibility for denture care is limited to the restoration of dental function to the pre-accident state. The addition of refinements to obtain a better cosmetic result is not the WCB's responsibility. Denturists should take into consideration the oral health of the worker prior to finalizing a treatment plan.

3. Workers cannot be billed directly under the WCA (Section 86). No part of the cost of any treatment provided to or in respect of a worker related to the compensable injury is payable by the worker. No additional costs in excess of this Agreement are payable by the worker.

4. The WCB will only pay for dental services provided to workers who are entitled to benefits under the WCA.

5. The investment in extensive and costly dental restorations should not exceed what the average worker would reasonably be expected to provide for themselves.

6. Where the worker's dental condition is extremely compromised, the cost of total extraction and replacement with dentures may be authorized where it appears to be a better alternative than repairing the specific work related injury. Replacement will be limited to once every five years if ongoing responsibility is accepted.

7. Pre-accident oral hygiene status will have some bearing on the authorization of denture procedures and must be reported to the WCB.

8. Elective dental care may be provided to a worker's dependent widow or children in some circumstances providing the worker's compensable accident occurred prior to January 1, 1982. However, approval must be obtained from the WCB prior to the commencement of any assessment or formation of a treatment plan. This applies particularly to work of a cosmetic nature. Due to legislative changes, dental care is not provided to dependent widows or children if the accident occurred after January 1, 1982.

9. The cooperation of all members of the College of Alberta Denturists in following these guidelines is appreciated and will assist in avoiding delays in payment and potential conflict with the WCB. Denturists must bear in mind that they and all health care providers are bound by the WCA.

Workers' Compensation Board
Alberta

Box 2415, Edmonton
Alberta T5J 2S5
Fax (780) 427-5863
1-800-661-1993

C884

DENTURIST REPORT

Authorization for dental services (excluding emergency treatment) must be obtained before proceeding with treatment.
Worker can not be charged directly.

Please print or type

WCB Claim Number

Personal Health Number

Patient's *Surname* *First Name* *Initial*

Date of Birth *(Year / Month / Day)*

Address *Street*

Postal Code | Telephone Number ( ) | Date of Accident *(Year / Month / Day)* | Is the patient working? ☐ Yes ☐ No

Employer's Name | Telephone Number ( )

Address *Street* *City/Town* *Province* *Postal Code*

Who provided first dental treatment? Doctor: | Date *(Year / Month / Day)* | The worker attended my office on: *(Year / Month / Day)*

History of injury:

Describe dental injury resulting from accident, include damage to any prostheses: (in point form)

Describe emergency treatment carried out:

Describe further treatment required as a result of injury:

Evidence of relevant pre-existing conditions? ☐ Yes ☐ No | If yes, please describe:

Any complicating factors affecting recovery? ☐ Yes ☐ No | If yes, please describe:

Dental X-Rays taken? ☐ Yes ☐ No | If yes, by Doctor: | Date of X-Rays *(Year / Month / Day)*

Referral to Specialist? ☐ Yes ☐ No | If yes, to Doctor: | Specialty Type:

Name and Address to whom fee is payable: (please print)

Provider's Signature:

Print Name:

WCB Billing Number.

Date *(Year / Month / Day)* | Telephone Number ( )

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

*** Please submit treatment plan preauthorization.**

C - 884 - 2005 Des: Date of Service CC: WCB, (RETAIN A COPY FOR YOUR RECORDS)

GENERAL INSTRUCTIONS FOR REPORT COMPLETION
DENTURIST REPORT (C-884)

REPORTING FEES

The WCB, in cooperation with the College of Alberta Denturists, has agreed to pay a report fee of $13.90 for the Denturist Report.

This agreement is based on the understanding reports will be:

- Legible
- Complete
- Of professional quality

Incomplete or illegible report forms will be returned unpaid.

DENTURIST REPORT COMPLETION

The denturist form is designed to be completed at the time of the examination and must be faxed, or mailed, to the WCB within two business days of the examination.

Type or Print	Legibility is important as all forms are electronically scanned.
Black Ink	Use **black ink only** to ensure a quality image is used for scanning into electronic files.
Electronic Form	Go to the WCB website (www.wcb.ab.ca) and under the *'Health Care Providers*' section go to *'Health Care Providers forms*' and select '*Denturists'* or simply type this address into your internet browser: **http://www.wcb.ab.ca/pdfs/c884.pdf**

This guide provides clarification of information required for the Denturist Report. The Denturist Report is to be completed at the time of examination and faxed or mailed to WCB within two (2) business days of the examination.

1. Is the patient working?

- Indicate whether or not the compensable injury affects the worker's ability to work.
- Missing time from work for appointments does not apply to this question.

2. Who provided first denture treatment?

- Indicate the name of denturist or facility where the first treatment was provided.
- Indicate the date of the first treatment.

3. The worker attended my office on:

- Indicate the first date that the worker attended your practice for examination or emergency treatment. This would be the same as 2) above, if you provided the first treatment.

4. History of Injury:

- Briefly describe the worker's explanation of the accident and the mechanism of the injury.
- Include the location, and the materials, tools or equipment involved in the accident in your description.

5. Describe dental injury resulting from the accident (include damage to any prosthesis).

- Describe damage to dentition or any prosthesis.
- Include any fractures, contusions or lacerations.
- Provide any other comments relevant to the case and the overall pre-accident oral hygiene.

6. Describe emergency treatment carried out.

- If emergency treatment is required during the visit, indicate the nature of that treatment.
- Attach a standard dental claim form for payment purposes of emergency treatment and the examination.
- Ensure you include the WCB claim number.

7. Describe further treatment required as a result of injury.

- Outline the treatment required to restore or repair the damage caused by the injury. The proposed treatment should not exceed what the average worker would reasonably be expected to provide for himself.

Remember to:

- Attach a standard dental claim form for authorization purposes.
- Ensure you include the WCB claim number.

8. Evidence of relevant pre-existing conditions.

- Document any pre-existing oral hygiene conditions that may have a bearing on the success of the proposed denture treatment.

9. Any complicating factors affecting recovery.

- Document other conditions or circumstances that may delay recovery, or have a bearing on the success of the denture treatment or recovery.
- This information will help us to determine the extent of injury attributed to the workplace and if there is a need for additional resources.

10. Were x-rays taken?

- Indicate by whom and the date taken.
- This enables WCB to request the results or the x-rays if required.

11. Referral to Specialist.

- Indicate whether the worker will be referred to a specialist.
- Provide the name of the specialist and specialty type.
- Where more than one specialist may be involved, a separate sheet should be attached to identify all specialist names, specialty type, addresses and telephone numbers.

****This enables WCB to gather all relevant reports.**

Fax or mail to the WCB:

Workers' Compensation Board
P.O. Box 2415
Edmonton, Alberta T5J 2S5

Fax within Edmonton:	427-5863
Fax outside Edmonton:	1-800-661-1993

We will accept forms faxed as original, provided it meets reporting requirements, is legible and of adequate quality. **If faxed, please do not mail the original.**

CANADIAN DENTAL ASSOCIATION

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. | SPEC. | PATIENTS OFFICE ACCOUNT NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER

SIGNATURE OF SUBSCRIBER

PATIENT

FIRST NAME _____ LAST NAME _____

ADDRESS _____ APT. _____

CITY _____ PROV. _____ POSTAL CODE _____

DENTIST

PHONE NO. _____

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES,OR SPECIAL CONSIDERATIONS.

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 COMPANY / PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PROCEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHEQUE NO. _____ DATE _____

DEDUCTIBLE	PATIENT PAYS	PLAN PAYS

CLAIM NO. _____

INSTRUCTIONS FOR CLAIM SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.
IF YOU PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.
*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.

PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. GROUP POLICY/PLAN NO. _____ DIVISION/SECTION NO. _____

EMPLOYER _____

NAME OF INSURING AGENCY OR PLAN _____

2. YOUR NAME (PLEASE PRINT) _____

YOUR CERT. NO. OR S.I.N. OR I.D. NO. _____

YOUR DATE OF BIRTH _____ (DAY MONTH YEAR)

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER _____

DATE OF BIRTH _____ (DAY MONTH YEAR) IF CHILD INDICATE: ☐ STUDENT ☐ HANDICAPPED

IF STUDENT, INDICATE SCHOOL _____

PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURACE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? ☐ NO ☐ YES

POLICY NO. _____ SPOUSE DATE OF BIRTH _____

NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPERATELY. ☐ NO ☐ YES

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT. ☐ NO ☐ YES

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? ☐ NO ☐ YES

6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

DATE _____ (DAY MONTH YEAR)

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

PART 4. - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

	DAY	MONTH	YEAR
1. DATE COVERAGE COMMENCED			
2. DATE DEPENDENT COVERED			
3. DATE TERMINATED			

4. CONTRACT HOLDER — DATE (DAY MONTH YEAR)

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

GENERAL INSTRUCTIONS FOR BILLING
STANDARD DENTAL CLAIM FORM

BILLING FORM COMPLETION

- Please use a Standard Dental Claim Form.
- Please provide your WCB billing number in place of your "UNIQUE" number.
- Please quote the WCB claim number above the patient's name and address.

A Standard Dental Claim Form should be submitted to WCB:

1. Following the worker's initial examinations;

2. Upon completion of any emergency treatment the worker requires;

3. As a means of preauthorization for further compensable dental treatment as a result of the accident. If possible, include an estimate of any laboratory charges;

4. Once all dental treatment is completed;

5. Please indicate on the claim form if it is submitted for the purposes of:
- preauthorization,
- completed emergency treatment,
- all compensable treatment has been completed.

ORDERING INFORMATION

Denturist Report Form (C-884)	Please order no more than a three-month supply. This will assist us in maintaining an adequate province-wide supply and also reduce costs.
Denturist Guides (C-617)	Additional Guides can be ordered by quoting number C-617
Form and Guide	Requests for the above forms and guides can be faxed to: Edmonton – 780-498-7882 Or by calling: 498-3999 – Customer Contact Centre (Edmonton) 1-866-922-9221 - Province wide toll free

QUESTIONS/CONTACTS

• Fees • Payment	Medical Aid, Financial Services If you have not received payment within three weeks of submission, you may wish to call: 780-498-4278	
• Patient's claim • Claim Number*	Customer Contact Centre Calgary: Edmonton: Province wide toll free:	 403-517-6000 780-498-3999 1-866-922-9221
• Discuss clinical aspects of the case • Assistance in completing reports.	WCB Dental Consultant Toll free: Calgary: Edmonton: Province wide toll free:	780-498-4119 or 4657 1-800-661-5419 403-517-6000 780-498-3999 1-866-922-9221

***NOTE:** **To ensure faster service when sending information to the WCB, indicate the worker's claim number.**