wcb Workers' Compensation Board – Alberta

C884
DENTURIST REPORT

P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: 780-427-5863
1-800-661-1993

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

WORKER DETAILS

Please print clearly

Surname	First Name and Initial	WCB Claim Number Date of Birth *(Year / Month / Day)*
Address Street		
Postal Code	Telephone Number ( )	**Date of Accident** *(Year / Month / Day)* — Is the patient working? ☐ Yes ☐ No

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.**