P.O. Box 160
Saint John, N.B.
E2L 3X9
Tel. 1 800 222-9775

WORKSAFE TRAVAIL SÉCURITAIRE NB

Claim Number:

ESTIMATE OF REQUIRED DENTAL SERVICES

TO BE COMPLETED BY ATTENDING DENTIST/DENTURIST AND FORWARDED PROMPTLY TO WORKSAFENB. PLEASE PRINT CLEARLY.

WORKER'S LAST NAME | GIVEN NAMES

ADDRESS | TELEPHONE

CITY/TOWN | POSTAL CODE | MEDICARE NO.

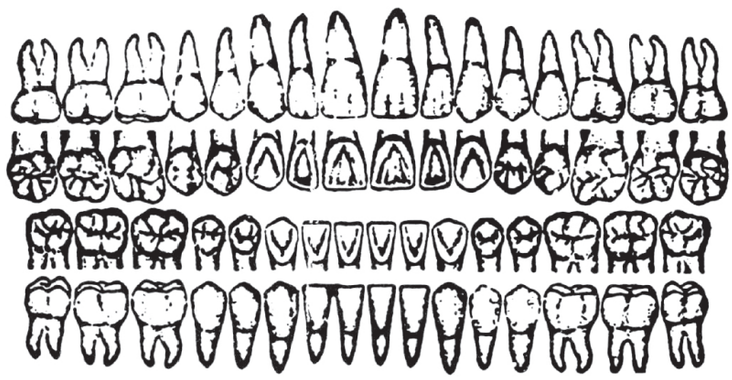
EMPLOYER'S NAME

EMPLOYER'S ADDRESS | POSTAL CODE

PART 1

MARK WITH LETTER "A" EACH TOOTH DAMAGED BY THIS WORKPLACE INCIDENT AND WITH THE LETTER "M" EACH MISSING TOOTH BEFORE THIS WORKPLACE INCIDENT.

RIGHT



LEFT

DATE OF INCIDENT: _____

DESCRIBE IN DETAIL THE DENTAL DAMAGE CAUSED BY THIS WORKPLACE INCIDENT: _____

PART 2

Indicate procedure code and estimate of cost following WorkSafeNB's ***Dental Fee Guide.***

PROCEDURE CODE	TOOTH NUMBER	LABORATORY CHARGE	DENTIST/DENTURIST FEE	TOTAL CHARGE

PART 3

Additional comments: _____

DENTIST/DENTURIST STAMP

SIGNATURE: _____

(DENTIST OR DENTURIST)

ADDRESS: _____

DATE: _____

Payee code: _____

(07/19)