DENTIST FORM

Please return completed form with your accident claim to your Provincial Sport Organization, 200 Main Street, Winnipeg, MB R3C 4M2. Any inquiries, contact Sport Manitoba, 925-5604.

PART 1 – DENTIST

Dentist's Name

Address

City, Province, Postal Code

Telephone

Patient's Last Name Given Names

Address

City, Province, Postal Code

Date of Serviced			Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge
Day	Mo	Yr						

This is an accurate statement of services performed and fees charged. E. & OE.

Total Submitted Fee

Dentist's Signature

Date: Day Month Year

FOR DENTIST'S USE ONLY:
For additional information re: diagnosis, procedures, or complications, and special considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.

Signature of Patient (or Parent/Guardian)

I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.

Signature of Subscriber

FOR PLAN ADMINISTRATOR USE ONLY:

NOTICE TO DENTIST:

Please Note – Under the terms of the Policy, this report must be forwarded to the Company within 90 days of the date of the accident. Your cooperation will be appreciated.

CLAIM APPROVED:

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage: _____

2. Is further treatment indicated? NO YES If "Yes" please indicate:

Int. Tooth Code		Treatment indicated – use procedure code if possible	Est. Date - Treatment Day	Mo	Yr.

3. Describe further potential problems and indicate time frame. _____

Date: Day Month Yr

Dentist's Signature:_____

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL