MANITOBA
PUBLIC INSURANCE

PLEASE READ FIRST...

Dental Report

Give this form to your dentist, including this cover sheet. Your dentist will complete the form and send it to us for review. *

*You need your Case Manager's approval before receiving dental treatment related to any injuries reported as a result of the accident.

For dentists only:

- Please complete the form fully, with all procedure codes and related M.D.A fee rates.
- By completing this form, you're outlining your plan for dental services and asking for our approval.
- This form is not an invoice. To receive payment for your services, please bill us separately for approved services.
- If, after sending us this form, you need to change the dental services you've outlined, submit a **new** form outlining the changes for the Case Manager's approval.
- Please include your office fax number. Faxing is the preferred method of correspondence to MPI. Please do not mail correspondence that was already faxed, as originals are not required.

(Cette forme est disponible en Français = This form is available in French).

MANITOBA PUBLIC INSURANCE

DENTAL REPORT

CHECK REPORT TYPE THAT APPLIES

- ☐ Initial
- ☐ Change in treatment
- ☐ MVA Re-treatment

EXAMINATION DATE: _____
dd mm yy

CLAIM NO.

Complete information is necessary for approval process

CASE MANAGER

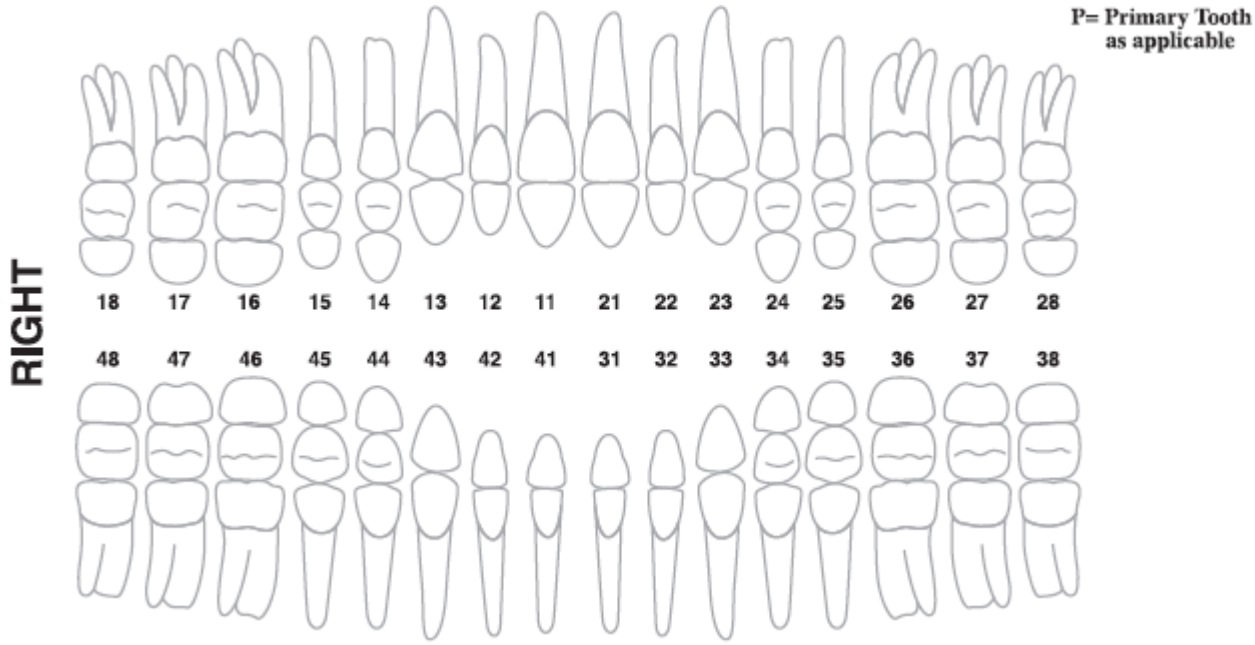
1. IDENTITY OF THE PATIENT:

Name	Age
Address	

2. DENTAL CHARTING:

1. **For Initial Report:** draw in ALL previous dental treatment & pre-existing missing teeth, caries & chipped teeth.
2. **For report type 2**: draw in change of treatment.
3. **For report type 3**: draw in treatment failure due to MVA-related dental treatment.

P= Primary Tooth as applicable



3. ORAL HYGIENE:

PRE ACCIDENT GOOD ◯ FAIR ◯ NEGLECTED ◯ UNKNOWN ◯
ACTIVE PERIODONTAL DISEASE YES ◯ NO ◯ UNKNOWN ◯
SMOKER ◯ **NON-SMOKER** ◯

4. DIAGNOSIS: (DENTIST ONLY)

Please indicate condition resulting from accident.

LEGEND: Does the injury relate to:

- ◯ A. Tooth structure only
- ◯ B. Previously restored portion of the tooth (eg. Filling, crown, bridge, denture, implant) only
- ◯ C. Both A and B

5. MECHANISM OF INJURY:

How did the dental injury occur as a result of the MVA? Report all damage as a result of the MVA, paying attention to extent and surface location.

6. MVA Re-treatment

☐ Failed treatment related to this MVA. Explain reason leading to failure. _____

7. TMJ ☐ Not Applicable to MVA ☐ Applicable to MVA

Jaw Opening: _____ (mm) between free edges of the upper and lower incisors
Protrusion: _____
Laterotrusion: Right _____(mm) Left _____(mm)

Pre-MVA TMJ treatment YES ◯ NO ◯ Date _____ Type: _____

8. Additional Issues: Referral(s) Required YES ◯ NO ◯

☐ TMJ
☐ Dental implant
☐ Bone grafting

If yes, name(s): _____

Contact info: Ph: _____ Fax: _____

9. ENCLOSURES:

Radiographs conventional / digital	☐ Most current Pre MVA	☐ Post MVA
Trimmed Casts	☐ Most current Pre MVA	☐ Post MVA
Photographs conventional / digital	☐ Most current Pre MVA	☐ Post MVA

If referring to denturist: Oral Health Certificate is required for complete dentures. YES ☐
Prescription for partial dentures is required. YES ☐

***When submitting your correspondence ensure tooth numbers, dates, claimant's name, and dentist name are labeled on all enclosures.**

10. HAS TREATMENT BEEN CONCLUDED? YES ◯ NO ◯ **PRE-AUTHORIZATION REQUIRED EXCEPT FOR EMERGENCY TREATMENT**

DATE SERVICE PERFORMED	TOOTH NUMBER	PROCEDURE CODE	M.D.A. FEE Recommended Fee Guide	Please separate: L = LAB CHARGES E = EXPENSE FEES	POTENTIAL FUTURE TREATMENT (Will require pre-approval)	PROGNOSIS (Yrs) 2-3 4-6 8-10 >10
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			

FORWARD COPIES OF ITEMIZED DENTAL LAB CHARGES AND EXPENSE FEES

Identify above if PC = Patient Choice

Regular maintenance of dental health and rehabilitation is the claimant's responsibility and lack thereof is not eligible for MPI dental benefits.

Declaration: To be completed by the Dentist.

I, (print surname and first name) _____, General Dentist, Periodontist, Prosthodontist, Maxillofacial Surgeon, other _____, hereby certify

a) That the dental injuries specified in this report result from a motor vehicle accident or are consistent therewith.
b) That the proposed treatment is solely to restore the damage sustained in the motor vehicle accident or MVA re-treatment failure.
c) That the type of treatment is consistent with the patient's pre-accident status and standard of dental care.
d) That I am providing services within my scope of practice and training.

PHONE NUMBER _____

FAX NUMBER _____
Faxing is preferred – originals not required

SIGNATURE _____
DENTIST

STREET ADDRESS | CITY OR TOWN | PROVINCE

MPI REGISTERED ACCOUNT NUMBER

DATE FORM COMPLETED _____
dd /mm /yy