WSI
North Dakota Workforce Safety & Insurance

# DENTIST'S REPORT OF INJURY

CLAIMS DIVISION
SFN 53449 (12/2016)

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
**Telephone 800-777-5033**
Toll Free Fax 888-786-8695
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

## SECTION 1 – *General information - completion of this section is required*

| Claim number | Worker's (First name) | (Last name) | Social Security number* | Date of birth |
|---|---|---|---|---|
| | | | | |

Worker's mailing address (Street address, PO Box number)

| City | State | ZIP Code | Worker's telephone number |
|---|---|---|---|
| | | | |

| Date of injury | Employer's name | Employer's telephone number |
|---|---|---|
| | | |

## SECTION 2 – *Dental assessment*

| Date of visit | Body part(s)/tooth number(s) |
|---|---|
| Diagnosis code/ICD-10 code(s) | CDT code(s) |

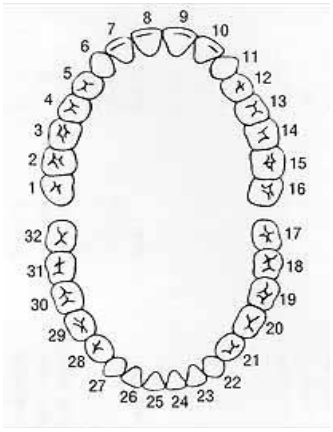
Purpose of visit
☐ Initial evaluation ☐ Re-check ☐ Discharge

Worker's description of injury

Does mechanism of injury coincide with finding?
☐ Yes ☐ No
If no, please explain

Prior to this injury, did the worker have any problems, injuries, or treatment to the injured body part(s)?
☐ Yes ☐ No
If yes, please explain

Please indicate injured teeth below




## SECTION 3 – *Dentist's estimate of physical capabilities – restrictions ordered are in effect for home and/or work activity*

Injured worker is released to work with ☐ No restrictions ☐ The following restrictions

| Restrictions are in effect until (date) | Date worker may return to work |
|---|---|
| | |

Has the injured worker reached maximum medical improvement?
☐ Yes ☐ No Date
If yes, is it likely that the permanent partial impairment will be greater than 14% whole body?
☐ Yes ☐ No ☐ Unknown

## SECTION 4 – *Follow-up plan*

| Date of next visit with this provider | Consult/referral (List provider) |
|---|---|
| Prognosis and anticipated length of dental treatment | Medications prescribed |

Other instructions, limitations, or future dental work

## SECTION 5 – *Release of information/fraud warning/signature*

By signing this form I acknowledge that I have read the fraud warning and release of information on the reverse side of this form. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.

| **Dentist's signature** | **Facility** | **Telephone number** |
|---|---|---|
| | | |

| **Worker's signature** | **Date signed** |
|---|---|
| | |

* In compliance with the Federal Privacy Act of 1974, disclosure of the Social Security number on this form is mandatory pursuant to N.D.C.C. § 65-05-02. The Social Security number is used for identification and verification purposes. Failure to provide this information may result in a delay in processing your request.

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**Release of information**

I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records.

In addition, I authorize any education agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S 21 Sec. 1232g. This authorization continues while I have any claim open or pending before WSI. WSI is exempt from HIPAA regulations. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

**Fraud warning**

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers' compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with WSI, including injured workers, employers, medical providers, and attorneys.