LEE-POWER & ASSOCIATES INC.

Dental Claim Form

Please Print

Part 1: Dentist

Unique No. | Spec. | Patient's Office Account No.

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

PATIENT

Last Name *Given Name*

Address *Apt.*

City *Prov.* *Postal Code*

DENTIST

Phone No.:

Signature of Plan Member

For Dentist's use only, for additional information, diagnosis, procedures, or special consideration.

I understand that the fees listed in this claim may not be covered by or may exceed my plan benefits. I understand that I am financially responsible to my dentist for the entire treatment cost. I acknowledge that the total fee of $ is accurate and has been charge to me for services rendered. I authorize release of the information contained in this claim form to my insuring company/plan administrator.

Duplicate Form ☐

Office Verification/Dentist's Signature

Signature of Patient (Parent/Guardian)

Date of Service D M YR	Procedure Code	Intl. Tooth Code	Tooth Surfaces	Dentist's Fee	Laboratory Charge	Total Charges

This is an accurate statement of services performed and the total fee due and payable. E&OE.

Total Fee Submitted:

Instructions:

1. Have your dentist complete Part 1
2. Complete all of Parts 2, 3 & 4.
3. If you wish benefits to be paid directly to the dentist sign the Assignment portion in Part 1, above right. Assignment of benefits is irrevocable.
4. Send form to:

Lee-Power & Associates Inc.
616 Cooper St.
Ottawa, ON K1R 5J2
Tel: (613) 236-9007
Fax: (613) 236-0329
E-mail: benefits@lee-power.ca
www.lee-power.ca

Part 2: Plan Member Information

Group Name: | Policy Number: | Certificate Number:

Plan Member's Name: | Date of Birth (D/M/Y):

Address: | Phone Number:

Part 3: Coordination of Benefits

Are you or any other member of your family entitled to benefits under any other group insurance plan, or Worker's Compensation?

☐ Yes ☐ No

If "Yes", what is the name of the family member insured: | Relationship to plan member:

Name of other insurance company: | Policy Number: | Spouse's date of birth:

Part 4: Patient Information

Relationship	Date of Birth	Full-Time Student?	Employed?
	Day/Month/Year	Complete only if claim is for a dependent	

Is treatment required as the result of an accident? ☐ Yes ☐ No (if yes please attach details/date of accident)

If claim is for denture, crown or bridge, is this the initial placement? ☐ Yes ☐ No

If "No", give date of prior placement and reason for replacement:

I authorize release of any information or record requested in respect of this claim to Lee-Power & Associates Inc. and the insurer and certify that the information given is true, correct and complete to the best of my knowledge.

Plan Member's Signature: | Date:

At Lee-Power & Associates we recognize and respect the importance of privacy. Personal information will be used solely for the purposes of assessing your claim and administering your group benefits plan.