LEE-POWER & ASSOCIATES INC.

Dental Claim Form

Please Print

Part 1: Dentist

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

PATIENT

Last Name *Given Name*

Address *Apt.*

City *Prov.* *Postal Code*

DENTIST

Phone No.:

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

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:
Local No. 7 - I.U.B.A.C. Benefit Trust Fund	**31702**	

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:

(Français au verso)

Electronic Dental Claims Now Being Accepted

LEE-POWER & ASSOCIATES INC.

As of October 1, 2003, Lee-Power & Associates Inc. can now accept your dental claims electronically. Your claims can be sent direct from your dentist's office to our claims department for processing. There are no forms to complete and mailing-in time is eliminated. Your claim cheque will be mailed to you after processing in the normal manner.

Nous acceptons maintenant les réclamations dentaires effectuées par voie électronique

Lee-Power & Associates Inc., accepte vos réclamations dentaires par voie électronique depuis le premier octobre 2003. Vos réclamations peuvent être envoyées directement du bureau de votre dentiste pour s'acheminer ensuite à notre section des réclamations afin que nous nous occupions de vous. Vous n'avez pas à remplir de formulaires et il n'y a plus de date d'échéance à respecter pour nous les faire parvenir. Votre chèque de réclamation vous sera posté suivant les étapes habituelles des réclamations.

Provide your dentist with the following information/Fournissant l'information suivante à votre dentiste:

Claims Administrator/administrateur des reclamations:	**Lee-Power & Associates Inc.**
CDAnet Carrier #/no CDAnet Carrier:	**627585 (NDC/ACE Network)**
Your Plan Information/votre information (plan):	**Policy #/no de police**
	Certificate #/no de certificat