

Date: [Date]

To: [Name of Dental Provider/Clinic]

[Address]

[City, State, Zip]

RE: Letter of Protection

Patient Name: [Patient Name]

Date of Birth: [DOB]

Date of Injury: [Date of Incident]

Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

This office represents the above-named patient regarding dental injuries sustained on the date referenced above. This letter serves as a formal Letter of Protection (LOP) concerning the payment for dental services provided to our client.

In consideration of your agreement to provide necessary dental treatment and/or evaluation to our client on credit, we hereby agree to protect your outstanding medical bills from any settlement, judgment, or verdict obtained on behalf of our client resulting from this injury.

By signing this document, our client directs this office to withhold sufficient funds from any recovery to satisfy your final billing. We further agree to pay those funds directly to your office upon the final resolution of the legal claim.

Please provide this office with a copy of all dental records and itemized billing statements as treatment progresses. We ask that you do not pursue active collection efforts against the patient while this legal matter is pending.

Sincerely,

[Attorney Name]

[Law Firm Name]

Acknowledge and Agreed:

[Patient Signature]

[Dental Provider Signature]