DELTA DENTAL®

Medicaid and Medicare Advantage Non-covered Services Form

Name of the patient along with any other identifying information:

_____

_____

Date of service:_____

Services provided to the patient that will not be covered by the patient's dental plan:

_____

_____

Charge of the services provided:_____

Signed statement by the patient (or guardian) that they agree to the charge and understand the services are not covered by their benefit plan.

I, _____, agree and understand the services listed above are not covered services under my dental plan and no payment will be made by my dental plan. I understand I will be responsible for all charges associated for such treatment and agree to pay all fees and charges for such treatment.

_____ _____

Patient signature Date

_____ _____

Parent or legal guardian signature *(if patient is under 18)* Date