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:

_____

_____

Charges 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

_____ _____

Patient or legal guardian signature Date
(If patient is under 18)