



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
(If patient is under 18)

Date