LIBERTY Dental Plan
Non-Covered Treatment Form

Non-Covered Services – Member Commitment Form of Responsibility	
Office Name/LIBERTY Facility ID #	**Provider Name**
Office Phone Number	**Date Presented**

Below are Non-covered services offered to patient/guardian based on their requests.

CDT Code	Procedure(s)*	Tooth/Arch	Fee*

Print:
Member ID: ___________________________ Member Name: _____________________________

Print:
Signed by Name: (Member, Parent or Guardian): ____

I understand AND agree to what was presented to me. Answer YES or NO to Each Statement Below:	**YES**	**NO**	**Initial**
My dentist advised me that the services I am electing are not a covered benefit through Medicaid, and I am electing to have these services, and understand they are my financial responsibility.			
My dentist advised me that there ARE covered services that would take care of my dental concern, but I am choosing **non-covered** services, and refusing the benefit offered through my plan.			
I understand I have to pay the dentist's usual fee for all elected and **non-covered services**, and that LIBERTY will not pay any portion of the cost.			

**I agree to pay for these dental services. If I fail to make each payment, I may be subject to collection action.*

Patient Signature (Parent or Guardian) Date

This signed form is required to be kept as part of the member's dental chart.

Revised: 3/2014