Non-Covered Treatment Form

LIBERTY DENTAL PLAN
Making members shine, one smile at a time™

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

Below are Non-covered services offered to participant/guardian based on their requests			
CDT Code	**Procedures***	**Tooth/Arch**	**Fee***

Enrollee ID #:	**Enrollee Name:**
Signed by Name (Enrollee, Parent or Guardian):	
*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 Signed:**

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

