

LIBERTY Dental Plan Consent for Non-Covered Treatment

Member			
Member Name:	ID#:		
Patient Name:	DOB:		
Address:	Phone:		
City, State, Zip:			
I understand that the below dental services are not listed as a covered benefit based on my dental coverage provided through LIBERTY Dental Plan. As indicated by my initials below, I am electing to receive these non-covered services at the agreed upon rate. My initials and signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.			
Treatment			
	Treatment Description	Cost	Datiant initial fan
CDT Code	<u>Treatment Description</u>	<u>Cost</u>	Patient initial for each elected code.
Dentist Signature:			
Member Signature: Date:			