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 services are not covered by LIBERTY Dental Plan, and that I am personally responsible for paying the dentist for these services. My signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.

Treatment

CDT Code	Treatment Description	Cost	Member Initials

Dentist Signature:_____ Date: _____

Member Signature:_____ Date: _____