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 show that I understand this financial responsibility and will pay the dentist when I receive his/her billing statement.

Treatment

CDT Code	Treatment Description	Cost	Patient initial for each elected code.

Dentist Signature: _____ **Date:** _____

Member Signature: _____ **Date:** _____

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

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