Notice of Non-Covered Services Consent Form

Your dental plan does not cover all services. Some services you or your health care provider feel are needed may not be covered. Delta Dental will not pay for non-covered services. If you do choose to have one of the services, your health care provider can bill you.

Before signing this form:

- Read this notice to make an informed choice.
- Ask your health care provider any questions that you may have.
- **This form must be presented and signed prior to the services being rendered on the date treatment is performed.**

Provider: Print this form; keep one copy in member file, give one copy to member.

Member Information

MEMBER LAST NAME	FIRST NAME	MI	MEMBER ID #	DATE OF BIRTH

Non-covered service/item-description (and code, if available)	
Reason(s) service/item is not covered by Medicaid	
Alternate covered service(s)/item(s)	
Cost of non-covered service/item	
Terms of payment	

Member Signature—Read the statement below, check the box if you understand and agree, sign and date.

☐ I want the non-covered service/item listed above. I understand that:

- The service or item is not covered by Medicaid and no payment will be made by Delta Dental
- I will have to pay for the service listed above and all fees associated will be my responsibility
- A different service or item may be covered by Medicaid and I do not want that service or item
- The provider may have asked for authorization and the authorization was denied

SIGNATURE—MEMBER OR LEGAL GUARDIAN/ AUTHORIZED REPRESENTATIVE/RESPONSIBLE PARTY	DATE	LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/ RESPONSIBLE PARTY NAME (Please print)

Provider Signature—Providers: As a participating provider in the Delta Dental network who is treating a Medicaid member, I understand and acknowledge, in accordance with the terms of my contract, I am only permitted to bill Delta Dental Medicaid members for non-covered services when members have agreed in writing, prior to the time services are rendered, to assume full financial responsibility for the non-covered services. I confirm and attest I have reviewed the dental services with the undersigned member or parent/guardian and that such services are not covered by Delta Dental and have not been denied by on the basis of lack of medical necessity or my failure to comply with the terms and conditions of my contract or any applicable Delta Dental policies. I attest I have offered the non-covered services, in good faith, to the undersigned member or parent/guardian based on my assessment of the undersigned member's needs and I have discussed the relevant health care services that Delta Dental does cover that can safely and effectively treat the undersigned member's health condition.

PROVIDER NAME	NPI/UMPI	PROVIDER SIGNATURE	DATE