

Medicaid and Medicare Advantage non-covered services form

Name of the patient along with any other identifying informat	tion:
Date of service:	
Services provided to the patient that will not be covered by the	
Charge of the services provided:	
Signed statement by the patient (or guardian) that they agre are not covered by their benefit plan. I,	
above are not covered services under my dental plan and no punderstand that I will be responsible for all charges associated network contracts and applicable state laws.	payment will be made by my dental plan. I
Patient signature	Date
Parent or legal guardian signature (if patient is under 18)	Date

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