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

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

Dentist Signature:_____ Date: _____

Member Signature:_____ Date: _____