

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.				
Troubusouk				
Treatment				Patient initial for
CDT Code		Treatment Description	Cost	each elected code.
Dentist Signature:		Date: _		
Member Signature:		Date: _		