

# Medicare Advantage Non-covered Services Form

Name of the patient along with any other identifying information:

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Date of service: \_\_\_\_\_

Services provided to the patient that will not be covered by the patient's dental plan:

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Charge of the services provided: \_\_\_\_\_

**Signed statement by the patient (or guardian) that they agree to the charge and understand the services are not covered by their benefit plan.**

I, \_\_\_\_\_, agree and understand the services listed above are not covered services under my dental plan and no payment will be made by my dental plan. I understand I will be responsible for all charges associated for such treatment and agree to pay all fees and charges for such treatment.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or legal guardian signature *(if patient is under 18)*

\_\_\_\_\_  
Date