



## Non - Covered Services Disclosure Form

### To be completed by Dentist Rendering Care

I am recommending that \_\_\_\_\_ receive  
*Member Name and Medicaid Number*  
 services that are **not** covered by Avesis' covered benefit and fee schedule. I am willing to accept a discounted fee of eighty percent (80%) of my **Usual and Customary Fee** as payment in full. The following procedure codes are recommended:

CODE	DESCRIPTION	FEES	80% of FEE

The total **discounted** amount for service(s) to be rendered is \$ \_\_\_\_\_

\_\_\_\_\_  
*Doctor's Signature* *Date*

### To be completed by Member

I \_\_\_\_\_, have been told  
*Print Your Name*  
 that I require services or have requested services that are not covered by Medicaid or PeachCare.

Read the question and check either YES or NO	YES	NO
My doctor has assured me that there are no other covered benefits.		
I am willing to receive services not covered by Medicaid/PeachCare.		
I am aware that I am financially responsible for paying for these services.		
I am aware that Medicaid/PeachCare is not paying for these services.		

I agree to pay \$ \_\_\_\_\_ per month. **If I fail to make this payment I may be subject to collection action.**

\_\_\_\_\_  
*Patient's Signature if over eighteen (18) or Parent or Guardian* *Date*