Agreement to Pay Non-Covered Services

Patient Name: _____

Member(Medicaid) ID: _____

Guarantor Name: _____

Relationship to Patient: _____

Not all dental services are covered by the TennCaer Dental Program. Some services are covered, but only within specific time frames (twice a year, once per year, once every 5 years, etc.) The following service(s) are recommended for the above named patient, but are not covered services:

Non-Covered Services

Code	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that the above services are not covered by the TennCare Dental program, and that I am personally responsible for paying the dentist for these services. My signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.

_____ _____

Guarantor Signature Date

Guarantor Address: *Guarantor Phone*

_____ Home: _____

Street, Apt # Cell: _____

_____ Work _____

City, State, Zip