Non-Covered Services Agreement

Provider____

Address_________________________________**City, State, Zip**_______________________

Telephone________________________________ **Fax**_________________________________

Email___________________________________ **Website**______________________________

Provider MA#____

I,_________________________ , understand that the following procedures are excluded under the Molina Healthcare program. I further understand that by signing this agreement, I am agreeing in advance, in writing, to accept full financial responsibility for all costs associated with these non-covered dental services.

Date of Service	Code	Description of Service	Cost
Total Amount Due by Recipient			

____/______________________

Patient Name/Patient MA#

____

Patient/Guardian/Beneficiary Name – Relationship to Patient

____

Patient/Guardian/Beneficiary Signature **Date**

____

Dentist Name

____

Dentist Signature **Date**

This form must be kept on file and a copy of which available upon request.