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Non-Covered Services Policy Statement

Following is a Non-Covered Services Policy Statement that was created in collaboration with the Preferred Dental Advisory Committee. This wording may be used at your discretion, however, we have often found that written agreements between the patient and the doctor help to clarify situations in which the patient will have financial responsibilities.

As your dentist, I want to provide you with your choice of dental services. There may be certain services that you select that are not covered by your Blue Cross and Blue Shield of Alabama Preferred Care contract. For other services(s) listed below, you will be expected to pay the fee schedule difference for that service or pay for the service in full. For example, your contract will pay for an amalgam (silver filling) for posterior teeth when a composite (tooth colored) filling is used. You will be expected to pay the difference up to the fee schedule amount for the composite filling. In addition, procedures that are considered cosmetic are not covered by your contract and you will be responsible for payment in full.

Let me reassure you that only service necessary and appropriate for your treatment and care will be preformed. If you have any questions, someone in our office will be happy to assist you. Thank you for your understanding.

Service(s) that may not be covered - as explained to the patient:

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Amount payable by patient ____________________________________

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I have read your policy and agree as indicated by my signature below to pay for service listed above that are not covered or for which payment is not allowed by my contract.

Patient's Name *(please print)* ______________________ Signature of Patient ______________________

Relationship to Patient ______________________ Date ______________________