South Cove's Non Covered Dental Care Acknowledgment Form

This agreement serves as an acknowledgment of pay for such services prior to **receiving non insurance covered dental treatment.**

本協議在收到非保險覆蓋的牙齒治療之前，承認此類服務的付款。

Services not covered dental insurance due to the following reasons:

非覆蓋牙科服務包括：

____Services not covered under the Masshealth, HSN, Scion, United Health Care Dental Programs.
不包括在Masshealth，HSN，Scion，United Health Care Dental Programs**下的服務**

____Services not covered for which dental insurance guidelines has been denied due to current dentition status. 顾客将会承担没有被保险承保的治疗费**用**

____Services not covered for which prior authorization has been denied or deemed not medically necessary **為此事先授權已被拒**絕或認為不必要的醫療服**務**

You will assume the risk of self-paying if denied by insurance **你**将会承担没有被保险承保的治疗费**用**

Non covered dental treatment provided: _____code:_____

提供非覆蓋牙科治療: _____code:_____

Cost of dental treatment: $_____
牙科治療費用:

Signature of responsible party: _____

責任方簽名:

_____

牙醫姓名(print): _____

牙醫簽名(Signature Of Dentist): _____ 日期: _____