Non-Covered Services Disclosure Form

This non-convered services disclosure form is intended for use for Medicaid recipients who seek non-covered (and in some instances, nonauthorized) services under Medicaid and who are agreeing, prior to any services being rendered, to pay the service provider for such non-covered services, thereby "waiving" the recipients' rights protected generally under the Federal Regulations that prohibit providers from balance billing Medicaid recipients for services rendered.

With this MEDICAID WAIVER, the provider acknowledges that for services that are not authorized or covered by UnitedHealthcare Dental (including Medicaid sponsored health care programs), the Medicaid Member must be informed of their payment responsibility prior to receiving the service and the Member must consent in writing.

Member Statement:

I understand that by signing this waiver form I am agreeing to be responsible to pay the provider for the services stated below as they are not covered or deemed medically necessary under my current health insurance.

That the specific service(s) sought are:

ADA Code and Description of Service _____

Fee: $ _____

That the service(s) sought is not a covered service under Medicaid guidelines;

That the service(s) is determined to be medically unnecessary before rendered;

That the provider does not participate in the Medicaid, either generally or for the services sought;

That I have been informed that one or more of the conditions listed (above) exists and, I voluntarily and knowingly agree to pay the provider for the charge they have indicated to me for these services.

By signing this waiver form, I certify that I am aware of the services covered by my health plan and of my rights under the Medicaid Program.

Member Name _____

Member Signature _____

Date _____