Health First Colorado Dental Non-Covered Service Disclosure Form

Health First Colorado (Medicaid) members may purchase additional dental services as non-covered procedure(s) or treatment(s) for an additional fee. Medicaid requires that the participating provider and the member complete the **Health First Colorado Dental Non-Covered Services Disclosure Form** prior to rendering these services. A copy of this completed and signed form **must** be kept in the member's treatment record. If the member elects to receive the non-covered procedure(s) or treatment(s) the member will be charged a fee, not to exceed the maximum rate of the participating provider's Usual and Customary Fees (UCF), as payment in full for the agreed procedure(s) or treatment(s).

The member is financially responsible for such non-covered service(s) or treatment(s) as defined by the Health First Colorado Dental Program in section 4.10 of the DentaQuest Office Reference Manual (ORM). The member may be subject to collection action upon failure to make the required payment. If the member is subject to collection action, the terms of the action must be kept in the member's treatment record.

Failure to comply with the Health First Colorado policy regarding non-covered services and member billing will subject the participating provider to sanctions up to and including termination as outlined in State statues (CRS 25.5-4-301)

This section to be completed by the participating provider rendering dental care:

I am recommending:

_____

(Member Name and Medicaid Number)

receive services that are **not** covered by the Health First Colorado Dental Program and Fee Schedule.

The Health First Colorado dental program encourages participating providers to bill members at or near the current fee schedule amount (FEES ARE NOT TO EXCEED PROVIDER'S UCF.) The following procedure codes are recommended:

Procedure Code (If applicable)	Description	Fee	Date(s) of Service

The total amount for service to be rendered is $_____.

_____

Participating Provider's Signature Date

This section to be completed by the member:

I _____ have been told that I require, or I have
Print Member Name
requested, dental services that are not covered by Health First Colorado.

Read the following statements and check Yes or No:

	Yes	No
1. My dental provider has assured me that there are no other covered benefits available to me as an alternative treatment option(s).	____	____
2. I am willing to receive services not covered by Health First Colorado Dental Program.	____	____
3. I am aware that I am financially responsible for paying for these services.	____	____
4. I am aware that Health First Colorado is not paying for these services.	____	____

I agree to pay $_____ per month towards the total amount due to my dental provider for the services rendered as outlined in this agreement. If I fail to make this payment, I may be subject to collection action by the participating provider.

_____

Member Signature Date

_____

Parent or Guardian Signature, if under 18. Date