Informed Consent for Payment

for Dental Procedures Not Covered
by the Connecticut Dental Health Partnership (the Dental Plan for HUSKY Health)

Dental Office: _____

Address: _____

_____

Patient Name: _____

HUSKY Health ID: _____ **Date of Birth:** _____

Responsible Person/Parent Name (if patient is less than 21 years of age): _____

Procedure(s) to be Performed: _____

_____

_____

_____

I knowingly understand that the above listed dental procedure(s) may not be covered (paid) by the Connecticut Dental Health Partnership (CTDHP). CTDHP is the Dental Plan for HUSKY Health (Medicaid/CHIP) because the procedures were determined not to be medically necessary.

I knowingly understand that if the dental procedure(s) listed are not covered I will have to pay for them myself. Or I can elect not to have these procedures performed.

The dental office has explained to me and I understand:

- **Why the procedure(s) are needed;**
- **How much the procedure(s) will cost;**
- **What method I can use to pay the costs not paid by CTDHP;**
- **When I must pay the costs.**

The dental office has given me a copy of this form.

I understand that I can call the CTDHP at 855-CT-DENTAL (855-283-3682). They are open Monday - Friday, 8 AM – 5 PM. They can answer questions about my dental coverage.

I knowingly and willingly agree to pay for these dental procedures performed that are not covered (paid) by CTDHP.

Signature: _____ **Date:** _____
(Patient or Responsible Party)

Signature: _____ **Date:** _____
(Witness)

Print Witness Name: _____ **Contact:** _____
(phone or email)