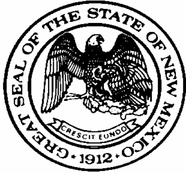

STATE OF NEW MEXICO

GENERAL SERVICES DEPARTMENT

715 Alta Vista, Santa Fe, New Mexico 87502-0110
Mailing Address: P.O. Drawer 26110•Santa Fe, New Mexico 87502-0110

Bill Richardson
GOVERNOR

Art Jaramillo
SECRETARY

FEE DISCLOSURE ACKNOWLEDGEMENT FORM

******NOTICE: Signing this form obligates you to pay your dentist for services that may NOT BE COVERED by your dental insurance, including your patient coinsurance, excluded services and amounts exceeding the annual maximum. The purpose of this form is to ensure your dentist has provided you with a good-faith range of possible costs for procedures recommended.***

****Please carefully read this form****

I, _______________________________________, acknowledge that my dentist, _________________________________, has provided me with the attached written description of the proposed services and the range of costs that represents the maximum I will have to pay; my insurance may or may not pay part of this total.

I am also initialing all the pages of the attached written description of services to show that I have read and fully understand the actual costs of and need for the services.

It is my dentist's responsibility to explain all changes to and options for treatment and to obtain my written acknowledgement of changes to the range of costs. It is my responsibility to understand and question the cost descriptions and all changes and options explained to me. I understand I have up to twelve (12) months, following completion of this treatment, to dispute the disclosure costs for this treatment.

I understand I have the option to request a written "Predetermination" from Delta Dental.

> ***A Predetermination is a notification of the services covered, how much Delta Dental will pay and what your financial obligation will be – prior to the treatment being performed. You may ask your dentist to file a dental claim form before treatment showing the services to be provided. Delta Dental will respond within 2 weeks with an Explanation of Benefits payable under your Plan and send it to you and your attending dentist. A Predetermination is subject to maximums, deductibles, eligibility and all other Plan provisions at the time the services are performed.***

____ ________________________
Signature of Patient or Personal Representative **Date**

____ _____________________
Signature of Dentist or Authorized Representative **Date**