UPGRADED & OPTIONAL / NON-COVERED TREATMENT FORM

PLAN____________________________________

		Plan Covered Treatment (do not leave blank)				Upgraded Treatment				Optional/Non-Covered Treatment			**Patient Accepts & Is Responsible For**		
Tooth No.	Existing Condition	ADA* Code	Description	Office UCR**-**A**	Pt. Pays Plan Copay-**B**	ADA* Code	Description	Office UCR**-**C**	Patient Pays (C-A) + B***	ADA Code	Description	Patient Pays Entire UCR**	**ADA* Code**	**Description**	**Fee**
3	Decay	2160	MOD Amalgam	$100.00	0	2387	MOD Composite	$185.00	$85.00	2643	Resin Onlay	$385.00	2387	MOD Composite	$85.00
11			Partial			6752	Four	$800.00		5225	Removable		5225	Removable	
12	Missing	5213	Denture	$1,000.00	$50.00	6240	Unit	$800.00	$3,200.00	5225	Partial	$1,300.00	5225	Partial	$1,300.00
13	Missing		with			6240	Fixed	$800.00		5225	Denture		5225	Denture	
14			Metal Framework			6752	Bridge	$800.00		5225	w/ Flexible Base		5225	w/ Flexible Base	
			Example of Totals	$1,100.00	$50.00		↑ **Examples of Computing Alternatives** ↑							**Example of Total**	$1,385.00
			Total Cost of Covered Treatment Plan											**Total Cost for Accepted Treatment (Patient Responsibility)**	

*ADA Code is the code for procedures as defined by the American Dental Association. Note: Your dentist may recommend treatments for which there is presently no ADA Code.
**UCR - Usual, Customary & Reasonable dental office fee
***Computation formula for upgraded treatment: UCR of Upgraded Treatment (Column C) - UCR of Covered Treatment (Column A) + Copayment for Covered Treatment (Column B) = Cost to Patient

I have accepted a treatment plan that may include upgraded and/or optional treatments that have limited or no coverage by my dental plan. My treatment plan has been fully explained to me in terms that I understand and any questions I have about my treatment have been answered before starting treatment. I understand the availability of plan covered treatments and their costs and, by my signature below, I agree to be responsible for the additional costs of any upgraded and/or optional treatments I have accepted.

Patient Signature ________________________________ Date

DO NOT SIGN IF YOU HAVE ANY UNRESOLVED QUESTIONS ABOUT PLAN COVERAGE OR FEES. FOR ASSISTANCE CONTACT CALIFORNIA DENTAL NETWORK MEMBER SERVICES.