Medicaid Advanced Beneficiary Notice
For Noncovered Services and Costs Exceeding Annual Limits

Medicaid Member Name _____

Medicaid ID Number _____

I understand the health care service(s) listed below is a service not covered by Medicaid, or dental service that may exceed the annual Medicaid dental coverage limit of $1,125. By signing this agreement for these services provided on the date below, I agree to pay for any non-covered service charges or balances owed for dental services exceeding the annual limit.

Service(s) being provided:

_____

_____

_____

Date(s) of Service(s) _____

Estimated Service(s) Cost _____

Member Signature _____ Date _____

Provider Name _____

Provider Address, City, Sate, ZIP Code _____

Provider Telephone Number _____

By signing this agreement, provider agrees not to bill Medicaid for any non-covered service(s) listed above, and will refund the member within 30 days, any amount overpaid by the member in accordance with this agreement and Medicaid rule.

Provider Signature _____ Date _____

This agreement must be signed by both the Medicaid member or legal representative, and the provider prior to the member receiving the service(s).