Non-covered services for Minnesota Health Care Programs Enrollees

As a provider of services to a Minnesota Health Care Programs enrollee using the CivicSmiles[sm] network, we are to notify you of any non-covered service under Minnesota Health Care Programs benefits. This notification will allow us to hold you financially responsible for the services listed below.

- Date service will be completed: _____
- Type of service to be provided: _____
- Total cost of service: _____

Your signature on this form serves as an authorization to provide the services listed above and to hold you financially responsible for the services.

_____	_____	_____
Provider	Clinic	Date

_____	_____
Patient Signature (parent if child is under the age of 18)	Date