Winston-Salem
Dental Care

Kenneth M. Sadler, DDS and Associates, PA
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(336) 331-3500 www.wsdentalcare.com

DENTAL BENEFITS NOTICE

Patient Name:	**Insurance Plan #1:**	**Insurance Plan #2:**

This is the Provider's Notice to the Beneficiary Regarding Service(s) that are Likely to be **Denied Payment** or **Partially Paid** by your Dental Health Insurance Plan(s) as "Non Covered, Partially Covered, Cosmetic or Out-of-Network.

Advance Notice to Beneficiary

Is is your responsibility as a subscriber or dependent of the subscriber to understand your dental health insurance benefits. Your insurance plan coverage has benefit limitations. Once limitations are met, your insurance plan will **NOT** cover additional services. The attending dentist/provider has done an assessment of your dental care needs. The attending dentist/provider has explained the procedure(s), process, alternatives and possibility for complications.

Your Insurance is likely to deny payment or partially pay for the following services(s) for the reason(s) noted below:

CDT Code	Description	Reason for Insurance Denials	Date of Service	Non Covered ☑	Partially Covered ☑
D2391-2394	**Composite Filling**	**Insurance company will alternate benefits and pay as an Amalgam performed on Molar Teeth.**			
D0210 D0330	Full Mouth / Pan	Prior to plan limitation (covered every 36 months)			
D1206	Fluoride/Varnish	Exceeds Maximum Age Limits			
D4211	Gingivectomy	Lack of Pocket Depth documentation			
D4910	Perio Maintenance	Periodontal therapy-not done			
D5820	Interim Partial	Posterior Teeth Not Covered			
D8692	Retainer-lost or broken	Non-Covered			
D9251-9242	IV Sedation	Not Covered with **only 1 extraction**			
D9940	Occusal Guard	Non-Covered Service			
Other:					

BENEFICIARY'S ACKNOWLEDGEMENT AND AGREEMENT TO PAY

I have been notified by my dentist / provider that he/she believes my insurance will likely deny payment or partially pay for the service(s) listed above and for the reasons stated.

I received a pretreatment estimate. I understand this is an estimated quote and **NOT** a GUARANTEE of expected payment in full from my insurance company.

Unexpected additional care may occur therefore this estimate is subject to increase depending upon my dental care needs. If my insurance denies payment or partially pays for services I received, I agree to be personally and fully responsible for payment to Kenneth M. Sadler, DDS and Associates, PA, Winston Salem Dental Care.

Beneficiary / Patient Signature_____ **Date:**_____

Advanced Dental Benefits Notice Form
Reviewed with patient by **WSDC employee:**_____ **Date:**_____

"Dental Care That Makes You Smile"