NOTCH
Northern Tier Center for Health
Federally Qualified Health Center

Vermont Medicaid Advanced Beneficiary Notice

Name:_____ DOB:_____ Date of Service:_____

As a courtesy, we assess Vermont Medicaid eligibility based on the Medicaid insurance card and information you provide. It is difficult to accurately determine the amount of coverage Vermont Medicaid will apply towards the services you are seeking. Due to this uncertainty, this notice is to inform you of the following:

- Northern Tier Center for Health will bill Medicaid for you if complete and proper paperwork and insurance cards are provided to us.
- Copayments are due at the time of service.
- You are financially responsible for any service provided to you that is not paid by Vermont Medicaid.
- You are financially responsible for services received which are not billable to Vermont Medicaid.

Item(s) or Service to be rendered:

☐ Sealants ☐ Silver Diamine Fluoride (SDF) ☐ Replacement of missing teeth (dental prosthesis)
☐ Treatment of crooked teeth (growth abnormalities) ☐ Dental restorations (Fillings, Crowns)
☐ Other:_____

I agree to receive the above services and understand I am fully responsible for the payment on these service that are not covered by Vermont Medicaid.

Signature:_____ Date:_____

☐ Patient ☐ Guardian/Healthcare Agent
If the person giving consent in not the patient, documentation of legal guardianship or healthcare agent assignment is required.
Guardian/ Healthcare Agent current Address: _____Phone: _____