Patient requested the following out-of-benefit services/upgrades (tariff code, NAPPI code where applicable and costs).

Note: Please add addendum if not enough space.

1. 

2. 

3. 

4. 

Patient agreed to the following services not covered (please indicate applicable tariff codes and costs).

Note: Please add addendum if not enough space.

1. 

2. 

3. 

4. 

I, the undersigned declare the following:

➢ That I was informed by my dentist that the medicine/investigation/procedure fall outside my benefits;
➢ That I am aware that the medicine/investigation/procedure fall outside my benefits and that I am responsible for the payment of these services.

Signed at __________________________ this day of __________________________ 20____

Signature __________________________ Date __________________________