JOLLEY SMILES
ORTHODONTICS

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Medicaid Loss of Coverage Agreement

I, _____ have been told that I, or my child, require or have requested orthodontic services that will be submitted to Health First Colorado (Medicaid) for approval or denial.

Read the following statements and initial:

_____ I understand that if I am (or my child is) approved, Health First Colorado will pay an initial payment to Jolley Smiles after the braces go on. They then continue to pay Jolley Smiles throughout the course of orthodontic treatment. Due to the way Health First Colorado pays, I understand I must maintain an eligible status for the duration of treatment to receive the full benefit.

_____ If I become (or my child becomes) ineligible with Health First Colorado and cannot regain eligibility within a reasonable amount of time (1-2 months), I understand that to continue with orthodontic treatment I must pay $161 per month via automatic payment to Jolley Smiles or choose to discontinue treatment.

_____ If I choose to continue treatment after becoming ineligible and I fail to make payment, I understand I may be subject to collection action and/or termination of treatment by Jolley Smiles.

Patient Name: _____

Patient/Parent Signature: _____