# Patient Refusal of Recommended Treatment Form

NAME OF INDIVIDUAL: _____DATE: _____

NAME OF MCO: _____

I,_____have chosen to refuse and not to consent to the dental treatment(s) that has been recommended to by my dental provider and the dental benefits manager for the State of Tennessee. All risks and benefits of the specific treatment has been explained to me, and I have elected to decline the service.

Reason for Refusal:

_____

_____

_____

_____

Individual/Guardian Signature Date

_____

Support Coordinator Signature Date