

Coverage Waiver Form

PATIENT NAME LAST, FIRST, MI	DATE OF BIRTH (MO/DAY/YR)	MEDICAL RECORD #	ACCOUNT #
------------------------------	---------------------------	------------------	-----------

This form is for use for commercial insurance and Medicaid carriers and must be completed **prior** to services being rendered.

- Chose Type of Coverage
- Commercial Insurance
 - Medicaid
 - Out of State Medicaid
 - CHIP

Section 1 Reason(s) personal representative may be billed (check all boxes that apply):

- _____ **may** consider this physician / facility to be non-participating.
Coverage Plan Name
- Your plan benefit **may** consider this service to be non-covered.
- Your health plan **may** consider this service or procedure to be medically unnecessary.
- Panel provider:* Your health plan **may** require an appropriate referral / authorization, which has not been received. (Not applicable for Medicaid recipients)
- Non-Panel provider:* Your health plan **may** require an appropriate referral / authorization, which has not been received.

Section 2 Description of service(s) for which the personal representative agrees to accept financial responsibility

Description of Service _____ Estimated Cost \$ _____ Date(s) of service: ___/___/___ to ___/___/___

Description of Service _____ Estimated Cost \$ _____ Date(s) of service: ___/___/___ to ___/___/___

Description of Service _____ Estimated Cost \$ _____ Date(s) of service: ___/___/___ to ___/___/___

This provider has an established policy for billing services that may not be covered. In accordance with state law, the personal representative has been advised **prior** to services being rendered, the specific service(s) to be provided and the expected cost.

Completed by _____ Date: _____
(Name / Title)

Section 3 Agreement of financial responsibility (Please choose **one** option. Check **one** box):

I am the personal representative. I understand my benefits provider may not pay for these services for the reason(s) indicated in Section 1. The contents of this form have been explained to me, and I have voluntarily signed this agreement **before** receiving the described services. I have been told what the estimated costs will be. I agree to pay for the service as described in Section 2.

- Yes.** I want to receive these services.
- No.** I have decided not to receive these services. I will notify my referring physician of my decision.

Signature of personal representative: _____ Date: _____

Relationship to Patient: _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with them. Your health information which your insurance company sees will be kept confidential by them.