How to complete a Non-covered services waiver

Allina Health LABORATORY

Medicare Replacement products do not pay for most screening tests, or tests deemed experimental or not medically necessary. In order to comply with those applicable replacement plan guidelines mandating covered ICD codes, Allina Health Laboratory will require a waiver for those applicable Medicare Replace Product patients when National Coverage Decision testing is ordered without coverable ICD diagnosis code(s) justifying medical necessity.

A completed waiver for those applicable replacement plans must be signed by the patient and submitted with the specimen.

In order for a waiver to be considered valid, the following must be completed:

- **Service:** Enter the name(s) and/or CPT codes of the non-covered test(s)
- **Estimated price:** Enter the estimated price of the non-covered test(s)
- **Reason:** Enter “Non-covered”
- **Date of service:** Enter the date that the test is to be provided (date of collection)
- **Options:** The patient must indicate either Option 1 or Option 2
- **Date:** The date of signature must be completed
- **Signature:** Either the patient or representative must sign. If a representative signs on behalf of the patient, they must include “(representative)” behind their signature
- **Relationship:** If a representative signs on behalf of the patient, they must indicate their relationship to the patient

A copy of the completed/signed waiver must be given to the patient.

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As a participating provider with your insurance, we are to notify you of services that may not be covered. This notification will allow us to hold you financially liable for the procedure listed below:

Service: ***Enter name(s) and/or CPT codes of non-covered test here***
Estimated Price: $ ***Enter the estimated price of the non-covered test(s) here***
Reason (specific benefit limitations): ***"Non-covered"***
Date of service: ***Enter the date that the test is to be provided (date of collection) here***

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you may have to pay for them yourself. Before you make a decision about your options, you should ***read this entire notice carefully.*** If you don't understand why you insurance likely won't pay, ask us to explain. Ask us how much these services will cost you.

PLEASE CHOOSE ONE OPTION; CHECK ONE BOX ONLY.

Option 1. ☐ YES I want to receive these items or services I understand that my insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to m…urance denies payment, I agree to be personally and full… This is. I will pay personally, either out of pocket or throug… I have. I understand that I can appeal the insurance com…
Option 2. ☐ NO I have decided n… …ems or services I will not receive these it… …derstand that you will submit a claim to my insu… …t be able to appeal y… insurance won't pay.

The patient must select one of the 2 options for the waiver to be valid.

Both the date and signature must be completed in order to be valid

Only needed if someone signs on the patient's behalf

Date _____ Signature of patient or person acting on patient's behalf _____ Relationship _____

Patient Name: _____ ***Enter the patient's name, legibly printed, here.***

Patient Allina Health MRN or DOB: _____

…is completed/signed document to the patient.

If a representative signs on behalf of the patient, they must include "(representative)" behind their signature.

The patient must be given a copy of the completed form.

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