Non-covered Services Waiver example

Allina Health Aetna MR, Blue Cross Medicare Advantage MR, Coventry HC Advantra MR, Health Partners Medicare Advantage MR, Humana Gold MR, Medica Advantage MR, Medica Dual Solutions MSHO, Medica Prime Solutions MR, South Country Health Alliance MSHO, UCARE Medicare Complete, UCARE Medicare Plans MR (includes UCARE for Seniors and UCARE Medicare Advantage), UHC Medicare Complete

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 <u>ONE</u> 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 r…surance denies payment, I agree to be personally and fully…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 yo… 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: _____

…his 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.