Non Covered Services Waiver

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

Allina Health LABORATORY

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:
Estimated Price: $
Reason (specific benefit limitations):
Date of service:

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 my health insurance. If insurance denies payment, I agree to be personally and fully responsible for payment. This is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal the insurance company's decision.
Option 2. ☐ NO I have decided not to receive these items or services	
	I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that insurance won't pay.

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

Patient Name: _____

Patient Allina Health MRN or DOB: _____

Provide a copy of this completed/signed document to the patient.