Non-Covered Services Disclosure Form

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Section to be completed by the PROVIDER rendering care

I recommend that _____ receive services that are not covered by his/her health plan.
Member Name and Identification Number

I will accept my usual and customary fee as payment in full. The following procedure codes are recommended:

Code	Description	Fees

The total amount due for service(s) to be rendered

_____
Member Name and Identification Number Date

Section to be completed by the MEMBER

I _____, have been told that I require services that are not covered by my health plan.
Member name (please print)

My doctor has assured me that there are no other covered benefits. ☐ Yes ☐ No

I am willing to receive services not covered by my Health Plan. ☐ Yes ☐ No

I am aware that I am financially responsible for these services. ☐ Yes ☐ No

I am aware that my Health Plan is not paying for these services. ☐ Yes ☐ No

I agree to pay _____ per month. If I fail to make this payment I may be subject to collection action.

_____
Member's Signature (if over 18) or Parent/Guardian Signature Date

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