Noncovered Items Statement

Patient's Name: _____ **Contract #:** _____

NOTE: You need to make a choice about receiving these health care items or up-grades.

We expect that your insurance carrier will not allow the item(s) or up-grade(s) that are described below. Your insurance carrier only allows covered items when certain medical criteria for coverage are met. There may be a good reason your physician recommended it, however, in your case, **your insurance carrier will not allow the following:**

ITEM (S) or UP-GRADE (S):

1. _____

2. _____

3. _____

REASON NOT ALLOWED:

_____

PATIENT'S ESTIMATED COST: $_____

The purpose of this form is to help you make an informed choice of whether or not you want to receive these items or up-grades, knowing that you will be held responsible for payment of them yourself. Before you make a decision about your options, **you should read this entire notice carefully,** ask questions of why your insurance carrier will not allow this item(s) or up-grade(s) and the amount you are expected to pay for them.

PLEASE CHECK BOX BELOW, THEN **SIGN & DATE**

☐ **YES. I want to receive these items or services.**

I understand that my insurance carrier will not decide whether to allow unless I receive these items or up-grades. Please submit my claim to my insurance. I understand that you may bill me for items or up-grades and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that
I have.

_____

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