

Non Covered Services Waiver

Humana Gold MR, Medica Prime Solutions or UCARE MR



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 your 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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.