

Non-Covered Services Liability Acknowledgement

This form should not be used in state(s) where a designated form is required.

Member Name: _____

Member ID#: _____

Health Plan: _____

Type of Program: ___ Medicaid ___ CHIP ___ Medicare Advantage ___ Commercial

Provider Name: _____

Provider Address: _____

Date of Service: _____

I (the member or if a minor, guardian of the member as listed above) acknowledge that it has been explained to me that certain health care service(s) or supplies that I have requested or wish to purchase will not be covered under the terms of my Health Plan benefit schedule. The non-covered service(s) that I have requested are:

I also acknowledge that I have been advised that these services are optional and as such, I will be responsible for payment for these non-covered services and agree to make arrangements with the Provider for such payment, directly to the Provider of these services.

Member Responsibility

Member/Guardian Signature

Date Signed