

## Non-Covered Services Agreement

I, \_\_\_\_\_, being a patient of Dr. \_\_\_\_\_ located at \_\_\_\_\_, do hereby acknowledge that it has been explained to me that a certain portion of my care will not be covered under the terms of my Health Plan. The portion of care not covered is: \_\_\_\_\_

I acknowledge that I have been told *in advance of treatment* what portion of my care I will have to self-pay for and I agree to make financial arrangements with the aforementioned Provider to pay for these services myself.

Dated at \_\_\_\_\_,  
(Office Name)

\_\_\_\_\_  
(Office Address)

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.  
(Date) (Month)

\_\_\_\_\_  
(Patient Name - Print)

\_\_\_\_\_  
(Patient Name - Signature)

Member I.D. # \_\_\_\_\_

Plan Name \_\_\_\_\_

If you feel you have not been offered alternatives that are within the benefit limits and/or allowance amount, or feel uncomfortable signing this agreement, please contact member services at (800) 508-6775.