Prima CARE P.C.

Non-Covered Service Waiver Form

I understand that my health insurance may not cover the office visit, procedure, or imaging (radiology) study performed today by my Prima CARE medical provider or by one of the Prima CARE testing facilities. If insurance does not cover the cost of my care, I will be responsible for the costs that are not covered by my insurance. My provider, or a member of his/her staff, has informed me that my health insurance may not cover this visit, procedure, or imaging because:

- ☐ the diagnosis for which this procedure has been prescribed does not meet Medical Policy Guidelines, or
- ☐ the procedure is not considered medically necessary, or
- ☐ Medical Technology Assessment Guidelines used by my insurance company have not been met, or
- ☐ I did not obtain a valid referral for this office visit and/or this procedure.
- ☐ **In the case of mammography (breast cancer screening), insurance may not cover today's study if screening mammography was performed recently (usually within 1 year) at Prima CARE or any other facility and if the mammogram was paid by any insurance company**.
- ☐ Other reason: _____
  _____

Name of procedure(s) or service(s): _____

Estimated cost: _____

I understand that I am responsible for all costs associated with any office visit, imaging, or procedures performed today if these costs are not covered by my insurance.

Patient Name: _____

Patient Date of Birth: _____

Patient (or Patient Representative) Signature: _____

Date: _____

Revised September, 2018
Revised March, 2019
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