Notice of Noncovered Service to Managed Care Patients

Sample Form

Date: ________________

Patient Name: ____

Procedure: _______________________ Estimated Charge $_________________

Reason for noncoverage by carrier: ____

____

____

____

Your signature on the bottom of this form signifies that you understand that the service identified above is not a covered benefit under your managed care plan. Your decision to have this service rendered and your signature indicates an understanding that the procedure is performed strictly for cosmetic purpose, is not medically necessary, and therefore, should not and will not be submitted to your managed care plan for payment.

You will be responsible for payment in full at the conclusion of the visit and fully accept the fact that the charges incurred are out-of-pocket expenses and will not be reimbursed by your health care plan.

_______________________________ _______________________________
Patient name ***Date***

_______________________________ _______________________________
Witness ***Date***