

This sample may be used as a guideline when developing a waiver form. You may wish to consult with your legal counsel before adopting this format.

**NON-COVERED SERVICES WAIVER FORM**

I, \_\_\_\_\_ (list patient name and member number), understand that the services and/or supplies listed below may not be considered eligible for benefits (e.g., service may be determined to be not medically necessary, non-covered or investigational) by \_\_\_\_\_ (health insurer). I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and supplies. Since I have chosen to obtain the services and/or supplies listed below, I agree to be financially responsible for any and all related charge(s), if not covered by my insurance.

\_\_\_\_\_  
Services/Supplies Requested

\_\_\_\_\_  
Condition/Diagnosis

\_\_\_\_\_  
Approximate Cost of Service

\_\_\_\_\_  
Date of Service

SAMPLE