PATIENT CONSENT FOR NON-COVERED SERVICES

Not all services are covered by your health plan policy. All services must be medically necessary care, as defined by CHP's Professional Services Agreement, is reimbursed by your health plan. All services provided to you are subject to co-pays, deductibles, co-insurance and prior approval in some cases. For all services covered under the provider's contract, the provider cannot bill the patient for the difference between billed charges and what the health plan reimburses the provider.

Certain services are not considered medically necessary by your health plan. They may be helpful to you, but the terms of your plan do not pay for these services. These non-reimbursable services and/or supplies are typically the responsibility of the patient. Listed below are services not covered under your current health plan contract but are being recommended by your provider:

LIST OF NON-COVERED SERVICES/ITEMS:

Durable Medical Equipment:	Cost:	$
Supplements:	Cost:	$
Vitamins:	Cost:	$
Prescriptions:	Cost:	$
Laboratory Services:	Cost:	$
	Cost:	$
	Cost:	$
	Cost:	$
	Cost:	$
X-rays:	Cost:	$
	Cost:	$
	Cost:	$
	Cost:	$
Other:	Cost:	$
TOTAL COST OF NON-COVERED SERVICES:		**$**

I, _____, a patient of _____ acknowledge and agree that part of my care is not a covered benefit of my health plan. I acknowledge and understand that I will be financially responsible for this part of my treatment. I also acknowledge and understand the information listed below:

- My provider and I have discussed the reasons for requesting non-covered services and what my alternatives are; my provider has allowed me to make the final decision regarding such services.
- I have been advised the recommended services will not be covered by my health plan and I will be solely responsible for payment of the recommended services.
- By signing this document, I am agreeing to pay for these services and charges prior to such services being rendered.
- I understand this is not an ongoing authorization but is specific to the treatment plan discussed with me. The treatment plan includes:

  Specific non-covered service to be provided at _____ (location) between ___/____/___/ and _____/____/____

Specific non-covered services provided by _____ (provider) including _____# visits between ___/___/___ and ___/___/___

I understand the treatment plan is for a period no longer than three months. Should the treatment plan extend beyond that time frame a new authorization or a re-signing of this agreement will be required after ___/___/___.

Patient/Member Signature Date

Patient/Member Printed Name Date

Please provide patients with a copy of this document

The following section to be completed by the Provider:

I have discussed all information listed above with my patient and provide the following reasons why services are not covered:

Provider Signature Date