UNMC REGIONAL PATHOLOGY SERVICES

# Patient Consent for Non-Covered Lab Services

Patient's Name (please print) _____ MRN # _____

Insurance company _____ Insured/Guarantor Name _____ Member ID Number _____

This form serves to make you aware that your insurance company,_____ may not pay for the item(s) or service(s) described below. The fact that they may not pay for a particular item or service does not mean that you should not receive it. There is good reason that your healthcare provider has recommended it.

***Tricare beneficiaries only:*** *This waiver allows a network provider to collect billed charges for services denied as 'non-covered' (not a TRICARE benefit) from a Tricare beneficiary when the beneficiary has agreed, in writing, to waive his or her balance billing protection.*

**In your case, your insurance company is likely to deny payment for the following item(s) or service(s) on the anticipated date:**

Date: _____ Item/Service (code):_____ Estimated Cost: _____
Date: _____ Item/Service (code):_____ Estimated Cost: _____
Date: _____ Item/Service (code):_____ Estimated Cost: _____

**For the following reason(s):**

- ☐ You have elected to self-pay for the above item/service.
- ☐ It is a non-covered item or service, your insurance company will not pay for it
- ☐ Your insurance company does not pay for this item or service more often than the frequency limit
- ☐ The item/service is considered experimental or for research use and is not covered
- ☐ Other (explain):_____

☐ Option 1. **YES I want to receive these items or services.**
I acknowledge that I am signing this statement voluntarily, and that it is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charges for the services listed above that are denied by my insurance company or I have opted to self-pay.

☐ Option 2. **NO I have decided not to receive these items or services.**
I have elected not to receive these items or services and I understand that it is my choice to have these services provided to me at a future date and time.

Patient/Legal Guardian _____ Date _____

Relationship to patient (if other than patient) _____

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