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Member Financial Liability Acknowledgement Form

I have been informed by my physician or his/her designated representative that the following service(s): _____

_____ have been determined to be a non-covered/excluded service under my health plan, for one of the following reasons:

- My health benefits plan does not cover/excludes this type of service.
- My health benefits plan covers this type of service, but has determined that it is not medically necessary for me at this time.
- My health benefits plan covers this type of service, but requires that it be precertified or preapproved before it is provided to me.
- Other: _____

I hereby authorize the performance of the non-covered/excluded services indicated above and I agree to pay for these services.

Name of Patient

Date

Signature of Patient

Date

Witness: _____ Date: _____

(If patient is a minor or is unable to sign, signature would be by financially responsible person.)

Witness