Non-Covered Services Liability Form

Member Name _____ Member Date of Birth_____

Member Insurance/Health Plan Name _____

Member Health Plan ID# _____

Guarantor Name (if applicable) _____

Guarantor Relationship to Member _____

Provider/Office Name _____

Rendering Provider NPI _____

Prospective Date of Service _____

Notice of Non-Covered Vision Services

This agreement serves as formal notice that the services listed below are either not covered under the member's vision plan or will exceed the maximum vision benefit allowed based on plan contract.

The following services have been recommended by the provider above for the member listed and will not be covered by the member's vision plan:

CPT Code	Code Description	Fee

Total cost for non-covered services: _____

Member or Guarantor Acknowledgement:

I, _____, the responsible member or guarantor, acknowledge I have been informed the services listed above are not covered or exceed the benefit allowance of the member's vision plan. I understand I am personally responsible for payment for these services.

By signing below, I accept this financial responsibility and agree to pay according to the financial policies of the office.

Print Member Name _____ Member Authorized Representative? ☐

Member Signature _____ Date _____

Print Guarantor Name _____

Guarantor Signature _____ Date _____

**This form must be signed by the member or member's authorized representative and the guarantor, if applicable, BEFORE receiving any non-covered services or items and be retained in the member's record.*