PENNSYLVANIA DERMATOLOGY GROUP, P.C.
2301 Huntingdon Pike, Suite 202
Huntingdon Valley, PA 19006
(215) 947-7500

NOTICE OF NON-COVERED SERVICE WAIVER

Patient Information

Patient Name _____ Patient DOB _____

Insurance Carrier _____ Member Number _____

Procedure _____ Estimated Charge _____

Reason for Non-Coverage _____

Notice of Non-Covered Service

Your signature at the bottom of this form signifies that you understand that the service identified above is not considered eligible for benefits (i.e. service may be determined not to be medically necessary, non-covered or investigational) by your health insurance carrier.

Your decision to have this service rendered and your signature below indicates that you understand your health insurance coverage has certain restrictions and limitations, such as authorization requirements and non-covered services, and therefore will not be submitted to your health insurance carrier for payment.

You will be responsible for payment in full at the conclusion of the visit and fully accept the fact that the charges incurred are out-of-pocket expenses and will not reimbursed by your insurance carrier.

This office will at no time, now or in the future, submit a claim to your insurance carrier as the provider has deemed the service to be not medically necessary under the terms of this practice's contract with your carrier.

_____

Patient or Guardian Signature Date

_____

Witness Signature Date