TEXAS DERMATOLOGY CENTER, DR. MARY EVERS, D.O.

Notice of Noncovered Service to Managed Care Patients

Date: ___/___/___
Patient: _____
Date of Birth: ___/___/___
Date of Service: ___/___/___
Procedure: _____
Estimated Charge $ _____
Reason for noncoverage by carrier:
_____
_____

Your signature on the bottom of this form signifies that you understand that the service identified above is not a covered benefit under your managed care plan. Your decision to have this service rendered and your signature indicates an understanding that the procedure is performed strictly for cosmetic purpose, is not medically necessary, and therefore, should not and will not be submitted to your managed care plan 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 be reimbursed by your health care plan.

_____ You will not receive a coded receipt for the service(s) you were rendered. Your check or credit card slip is your receipt. If cash is paid, a cash receipt will be provided.
Initial

_____ 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.
Initial

_____ ___/___/___
Patient Signature Date

_____ ___/___/___
Witness Signature Date