RANCHO FAMILY
PRACTICE ASSOCIATES
We make it easy for you to feel your best

SPECIAL SERVICES NOTIFICATION FORM

Patient Name:_____
D.O.B._____ **Date of Service:**_____

Service/Test to be ordered or performed on above date of service
Health plan/Insurance Name:_____
(Insert name of insurance plan presented)

NOTICE OF NON COVERED SERVICES:

Your healthplan/insurance may not cover the above referenced service/test for any one, or all of the following reasons:

a. The service/supplies may not be a covered service as defined by your insurance.
b. The service/supplies may not be covered under the diagnosis provided.
c. Specific insurance requirements (i.e. prior authorization) are not met.
d. Rancho Family Practice Associates is not contracted with your health plan.
e. Verification of healthplan/insurance unavailable on date of service.

I understand that Rancho Family Practice Associates will bill my health plan/insurance as a courtesy only. I understand this document may be released to a third party if the payor request coordination of benefits information. I accept full financial responsibility for the services/supplies as referenced above, if not covered by my health plan/insurance.

_____
Financially Responsible Party's Signature **Date**

_____
Witness if needed **Date**