Non-Covered Services Waiver

As a member of Children's Physicians Medical Group (CPMG)/Rady Children's Health Network (RCHN), I understand that the service/s : ____________________ being provided by:________________ may not be a covered service/s. If the service/s is not covered by my health plan, I understand that I may be required to pay for the service/s in full.

☐ My Provider has explained that the service/s I am requesting may not be a covered service/s.

☐ I understand that I am responsible for payment to _____________. My questions have been answered and I agree to pay in full for the service/s requested.

☐ I have reviewed my options and will not be receiving the service/s requested.

Member ID: ____

Health Plan: ____

Member Name: ____

Authorized Signature: ____________________________________

Relationship to Patient: ___________________________________

Date: ____