

ADVANCED NOTIFICATION OF NONCOVERAGE (ANN)

Waiver of Liability

This waiver form is signed after you have been informed that it is likely that payment for an item or service listed below may be denied by your insurance contract as excluded or not medically necessary. The waiver statement below indicates that by signing this form, you are assuming financial responsibility for the costs identified.

Laboratory Test(s)	Estimated Cost	Reason Insurance May Not Pay
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Acknowledgement of Non-Covered Services

The purpose of this form is to notify you of financial liability for the above-identified test(s) in the event your insurance plan does not pay.

The fact that your insurance may not pay for a particular test does not mean that you should not receive it. There may be a good reason your doctor recommended it.

By signing this form, I agree to personally and fully pay for the costs identified above as “patient responsibility” if my insurance plan denies payment.

Print patient name

Date

Signature of Patient or Patient's Representative

(If Patient's Representative, under what legal authority are you signing?)

Parent

Guardian

Health Care Agent

Other (specify): _____