NSM Waiver of Non-Covered Services (Non-Medicare)

Client Name: _____

Address: _____

City/St/Zip: _____

Work Order #: _____

Your Payer will only pay for services that it determines to be reasonable and necessary under their coverage policies.

If your Payer determines that a particular service is “not reasonable and necessary”, “statutorily non-covered” or “not medically necessary” under their policies, they will deny payment of that service(s).

Your Payer is likely to deny payment or only make payment for the standard service or supply for the following service(s) for the following reason(s):

☐ Item is non-covered by your Payer per the attached Payer Policy.
☐ After prior authorization/pre-certification/pre-determination review, your Payer deemed this non-covered or not medically necessary per the attached Payer decision.

I, _____, am requesting to purchase the item(s) and/or service(s) listed below. I understand that I am fully responsible for the total billed charge and that I understand and acknowledge that NSM cannot file a future claim for the item(s) and/or service(s) and reimburse what I paid. I also understand that I cannot file a claim on my own.

I further understand and acknowledge that any future services or repairs related to the item(s) and/or service(s) will also be non-covered by my health insurance plan, and if such future services or repairs are requested by me, I will be financially responsible for such services or repairs.

I acknowledge and understand that NSM is not the manufacturer of the requested item(s), did not prescribe the requested item(s) and makes no representations with regard to medical suitability of the requested item(s) and/or service(s).

I acknowledge that I am signing this waiver voluntarily at my own request and that it is not being signed under duress or after the item(s) or service(s) have already been provided.

Item(s) and/or Service(s):	**Estimated Cost:**
_____	_____
_____	_____
_____	_____

Patient‘s name: _____

Patient‘s signature: _____ **Date Signed:** _____

Authorized representative‘s name: (please print) _____

Authorized representative‘s signature: _____ **Date Signed:** _____

Relationship to patient: _____

Reason patient cannot sign: _____