BlueCross BlueShield of Kansas

An Independent Licensee of the Blue Cross and Blue Shield Association.

LIMITED PATIENT WAIVER

Patient's Name: _____

Identification Number: _____

Provider Name: Kansas Pathology Services, LLC

Provider Address: 2501 E 13th Building 2, Suite 4

Hays, KS 67601

Provider Number: 1144311986

The provider must document in the patient record the discussion with the patient regarding the following service(s).

NOTICE OF PERSONAL FINANCIAL OBLIGATION
Read Before Signing

I have been informed and do understand that the charge(s) for _____
(nomenclature/procedure code/appliance)

provided to me on _____ (date) will not be covered because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service(s) to be:

- ☐ Not medically necessary
- ☐ Utilization denials
- ☐ Deluxe features (Applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) [the allowance for a standard item(s) will be applied to the deluxe item(s)]
- ☐ Patient demanded services
- ☐ Experimental or investigational

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS.

I UNDERSTAND THAT I WILL BE HELD PERSONALLY RESPONSIBLE FOR APPROXIMATELY $ _____. This amount is an approximation only, based on the service(s) scheduled to be provided.

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

_____ _____

Patient/Parent/Guardian Signature Date

I, _____(witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

_____ _____

Witness Signature Date

_____ _____

Patient Refusal/Service(s) Not Performed Date

#15-169 (10/09)

Contains Public Information