



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

LIMITED PATIENT WAIVER

Patient's Name: _____

Provider Name: _____

Identification Number: _____

Provider Address: _____

Provider Number: _____

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