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NON-COVERED SERVICES WAIVER FORM

I, _____, understand that the services for _____ as listed below may not be considered eligible for benefits (e.g., services that may be determined to be not medically necessary, non-covered, or experimental and investigational) by _____. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements and non-covered benefits. Since I have chosen to obtain the services listed below and have them billed to my insurance company, I agree to be financially responsible for any and all related charges, should the insurance not cover the services.

Vision Therapy _____ 92065 _____
Service Requested — Procedure Code

_____
Condition/Diagnosis

$_____
Approximate Cost of Service, per session

_____ _____
Member or Legal Guardian Signature — Date

This form is to remain in effect until the end of the calendar year period, (Jan 01-December 31st). This means that all dates of services for the same service will be included in this non-covered service form.

_____
Initials