BaylorScott&White
CARDIOVASCULAR CONSULTANTS
A member of HealthTexas Provider Network

Insurance Waiver

Patient Name: ____________________ ID # _________________ DOB _________________

PROVIDER STATEMENT:
Based on the information that you have provided to us, we believe that it is likely that your insurance company ______________________ will limit or deny coverage for the following items or services:

ITEM(S) / SERVICE (S)	ESTIMATED CHARGE (S)
Coronary Calcium Scoring	**$100.00**

REASON CODES (check all that apply)

_____ Patient did not have insurance card, patient agrees to call information back to our phone number ________________ by ____________ or will be billed as self pay.
(Phone #) (Date)

_____ Our Facility/Provider is not a contracted facility/provider for the above listed service(s).

_____ Your insurance company may determine that the following service is not a covered benefit for the diagnosis that was provided to use by your physician: ____.

_____ You have reached the maximum benefit provided by your insurance company for this service, according to your insurance carrier. Certain frequency limitations may apply.

_X_ Your insurance company does not usually provide for screening or research testing.

_____ Patient understands that the physician from which (s)he will be receiving health services is not the PCP of record. Furthermore, patient understands that the insurance company will not pay for any health services rendered by a provider who is not the members' current PCP of record.

_____ Other:
(explain) ____

BENEFICIARY'S STATEMENT:

☐ Yes. I want to receive these items or services. I understand that my insurance company may not/will not pay. I understand that I am personally and fully responsible for the payment.

☐ No. I have decided not to receive these items or services.

_________________________________ _______________________________
Beneficiary Signature Date