TRICARE Beneficiary Liability Form (Waiver of Non-Covered Services)

This Waiver allows a network (contracted) provider to collect billed charges for services denied as "non-covered" from a USFHP member when the beneficiary has agreed, in writing, to waive his or her balance-billing protection.

I, _____ , the USFHP member, hereby agree to pay up to the full billed charge(s) for the following service(s) if such service is subsequently denied as non-covered regardless of the fact the TRICARE program will not make payment:

Date _____ Service (Code) _____ [Estimated] Billed Charge _____

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Date _____ Service (Code) _____ [Estimated] Billed Charge _____

Date _____ Service (Code) _____ [Estimated] Billed Charge _____

Date _____ Service (Code) _____ [Estimated] Billed Charge _____

TOTAL [ESTIMATED] BILLED CHARGES _____

Note: *This waiver applies to any and all TRICARE non-covered services indicated above rendered by this provider, including, but not limited to office visits, office procedures, hospital visits, and surgical fees.*

I acknowledge that I am signing this statement voluntarily, and that is is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) for any services denied as non-covered and listed above and will pay the provider this amount, regardless of the fact USFHP will not make payment. I also understand that it is my choice to have these services provided at a future date and time by this provider.

USFHP Member Signature _____ Date _____

USFHP Member Name (Printed) _____

Member Number _____ Relationship To Sponsor _____

PROVIDER INFORMATION

Providers must follow all applicable coding regulations. If an appropriate CPT code exists that covers several procedures rendered, the provider must use the all-inclusive procedure code and not bill for each procedure separately. If a TRICARE allowable amount exists for this code, the billed charge(s) can not be more than that amount.

Provider Name _____

Address _____

City _____ State_____ Zip _____ Phone Number _____

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