Medicare Member Consent for Non-Covered Services

Provider Name: _____ **Phone Number:** _____

Address:_____ **City:**_____ **State:** _____ **Zip:** _____

Chiropractic services that are covered by your health plan's chiropractic benefit, and eligible for reimbursement include:

- Manual manipulation of the spine to correct subluxation.

As your Doctor of Chiropractic, I want to provide you with the best care possible. In addition to spinal manipulations, there are other chiropractic services that are necessary to support my treatment, or that I feel would help the treatment of your condition and maintenance of good health, but are not covered by your health plan.

Services that are **not covered** by your health plan's chiropractic benefit, and not eligible for reimbursement, are outlined below. These services will be your financial responsibility **should you elect to receive them**. Your financial responsibility is limited to services received during the treatment plan as defined below.

Treatment plan start date: _____ **Treatment plan end date:** _____

Note: The defined treatment plan can not be more than 12 weeks long and should align with any applicable authorization denial

Non-Covered Service	Cost Per Visit*	Member Initials/Date
Exam(s)		
Manipulation (for maintenance care or wellness)		
X-ray(s)		
Therapies/Modalities (**Circle All Applicable Therapies**) Electrical Stimulation Acupuncture Other: _____ Ultrasound Exercise Education		
Durable Medical Equipment (**Circle All Applicable Products**) Braces Orthotics Ice Pack Other:_____		
Massage		
Other:		

*Patient's billed amount may not exceed the provider's usual and customary amount

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These services are not eligible for reimbursement through your health plan because (check one):

- ☐ They were determined to be maintenance or elective care, rather than treatment to improve a clinical condition, through the organization determination process
- ☐ They are excluded from your chiropractic coverage, even when related to treatment to improve a clinical condition

Provider/Authorized Health Care Representative Signature:_____

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability and the provider/staff has answered them to my satisfaction. **I understand that I have the right to refuse this care and request a prior authorization prior to receiving care. I understand that by signing this form, and receiving care at this time, I acknowledge that I am fully aware that the services listed above are not covered by my health plan and that I will be fully responsible for the total billed charge(s) related to the non-covered services.**

_____ Date: _____

Patient's Name

_____

Patient or Authorized Representative Signature

A copy of this signed form must be provided to the patient upon request