UnitedHealthcare MILITARY & VETERANS

TRICARE

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 TRICARE beneficiary when the beneficiary has agreed, in writing, to waive his or her balance-billing protection.

I, _____, the TRICARE beneficiary, 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: _____

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

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

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 it 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 TRICARE 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.

TRICARE BENEFICIARY SIGNATURE: _____ DATE:_____

TRICARE BENEFICIARY NAME: (PRINTED)_____

SPONSOR SSN: _____ RELATIONSHIP TO SPONSOR: _____

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.

PROVIDER INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE NUMBER: _____