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Norfolk Va. 23502

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HEALTHKEEPERS HMO WAIVER FORM

Date: _____

Patient's Name: _____

The services or supplies listed below are not covered by your HMO plan. If you would still like for us to provide you with the service and/or supplies, please sign below.

Service: _____

Supplies: _____

Fee: _____

Reason not covered:

_____ Service requires a referral and one has not been obtained.

_____ Service requires preauthorization and one has been denied by your insurance carrier.

Use of a waiver is NOT valid to circumvent the preauthorization process for a covered benefit. If a preauthorization is required and the provider neglected to request and receive preauthorization, a member is held harmless even if a waiver is signed.

_____ Service has been determined by your insurance carrier to be experimental, investigational or not medically necessary and therefore non-covered.

_____ Other _____

I understand that my HMO plan will not pay for the above services or supplies and I agree to be financially liable.

Signature

Date

Relationship to patient