



An Independent Licensee of the Blue Cross and Blue Shield Association.

LIMITED PATIENT WAIVER

Patient's Name: _____ Provider Name: Pathology Associates Medical Laboratories, LLC

Identification Number: _____ Provider Address: P.O. Box 2720
Spokane, WA 99220

Provider Number: 27-0943279

The provider must document in the patient record the discussion with the patient regarding the following service(s).

**NOTICE OF PERSONAL FINANCIAL OBLIGATION
Read Before Signing**

I have been informed and do understand that the charge(s) for vitamin D testing
(nomenclature/procedure code/appliance)

provided to me on _____ (date) will not be covered because Blue Cross and Blue Shield of Kansas (BCBSKS) considers this service(s) to be:

- Not medically necessary
- Utilization denials
- Deluxe features (Applicable to deluxe orthopedic or prosthetic appliances as specified in the member contract) [the allowance for a standard item(s) will be applied to the deluxe item(s)]
- Patient demanded services
- Experimental or investigational

For tests that have been ordered
Please check test below

It is my wish to have this service(s) performed even though it will not be paid by BCBSKS.

I UNDERSTAND THAT I WILL BE HELD PERSONALLY RESPONSIBLE FOR APPROXIMATELY
\$ _____. This amount is an approximation only, based on the service(s) scheduled to be provided.

	Code	CPT
___ \$ 80.99	VDOH	82306
___ \$118.47	VIDD	82652
___ \$172.14	VITD23	82306

Acknowledgment of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

Patient/Parent/Guardian Signature Date

I, _____ (witness name), did personally observe and do certify the person who signed above did read this notice and did affix their signature in my presence.

Witness Signature Date