

# Non-Covered Services Waiver Form

I, (printed name) \_\_\_\_\_, understand that the laboratory services listed below may not be considered eligible for benefits (e.g., services may be determined to be not medically necessary, non-covered or investigational) by my health insurance provider. I understand that my health insurance coverage has certain restrictions and limitations, such as prior-authorization requirements and non-covered service guidelines.

By signing this form I understand that I am agreeing in advance to receive these specific services and to pay for the services identified below\* if my insurer denies payment because the services are not covered by my health insurance plan.

(\* check test or tests below that have been ordered)

- |   |          |
|---|----------|
| <input type="checkbox"/> Vitamin D, 25-Hydroxy (VDOH, CPT 82306)      | \$ 85.05 |
| <input type="checkbox"/> Vitamin D, 1,25-Hydroxy (VIDD, CPT 82652)    | \$124.40 |
| <input type="checkbox"/> Vitamin D2 D3 25-Hydroxy (VITD23, CPT 82306) | \$180.75 |

Signed: \_\_\_\_\_

Date of Service: \_\_\_\_\_



A partnership with  
St. Mark's Hospital  
Ogden Regional Medical Center  
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