School of Medicine
UNIVERSITY OF COLORADO

Patient Identification Label
Name:_____
MRN: _____
DOB: _____
Date of Service: _____

HEALTH INSURANCE WAIVER

I have requested services and/or therapies provided by CU Medicine. I understand that benefits cannot be guaranteed until a claim is paid. I further understand I may be responsible for all charges incurred today ***even if I elect to have my insurance billed first.***

Estimate of University of Colorado Medicine's charges:

CPT/HCPC	Description	Estimated Charge
81479	Targeted Chromosomal Microarray	$444.60

This is only an estimate and may not be the full financial responsibility.

I acknowledge that my insurance may not cover the services listed for the following reason:

____My provider is believed to be out of network with my insurance plan.

____The service(s) listed below may not be covered by my insurance plan.

____The service(s) were not authorized by my health plan. I am choosing to receive care and understand that I am financially liable for charges incurred.

____I am electing NOT to have these charges billed to my insurance company. I understand no claim will be generated by CU medicine for these services. I will remit payment for service in full today.

_____ **Date**_____
Patient Signature (or parent/guardian/other-authorized person if patient is a minor, mentally incompetent, or physically unable to sign this form)

_____ **Date** _____
Printed Name and Relationship of Person Authorized to Sign for Patient

_____
Reason Patient is Unable to Sign

Insurance Waiver Explained by: _____
(Printed Name of Hospital or University of Colorado Medicine Rep.)

_____ _____
Signature of Hospital or University of Colorado Medicine Rep. **Date**