UT Southwestern Medical Center®

UNIVERSITY HOSPITALS & CLINICS

Advance Notice of Non-Covered Services

A. Health Plan: _____

B. Patient Name/MRN: _____

C. Subscriber Number: _____

Procedure(s):			
	VIDEO VISIT	Fee	$45
		Fee	
		Fee	
		Fee	
		Fee	
		Total Professional Fees	**$45**
		Fee	
		Fee	
		Fee	
		Fee	
		Fee	
		Total Hospital Fees	0
		Total Professional and Hospital Fees	**$45**

☐ initials

Your insurance company has informed us that this procedure(s) is **not a covered benefit** of your plan. A package price* for the non-covered procedure(s) has been established that is **due in full prior to your treatment,** and this procedure(s) will not be billed to your insurance company.

☐ initials

This procedure(s) may not be a covered benefit of your plan, but you have requested that we submit a claim for these services to your insurance.

- If your insurance covers any portion of this procedure(s), you are responsible for your normal/regular coinsurance and/or deductible amounts.
- If your insurance does not cover any portion of this procedure(s), you are responsible for the full price of any non-covered services.
- While we may have obtained an authorization from your insurance carrier for this procedure(s), you are responsible for the full price of any non-covered portion of the procedure should it be denied or payment recouped due to an exclusion in coverage determined by your insurance.
-The payment of your estimated out-of pocket balance after insurance and any package plan amount is **due in full prior to the procedures being rendered.**

*This package pricing information includes only those services listed above. It does not include additional anesthesia, laboratory, pathology or radiology/imaging services that may be required by the facility or additional procedures that may be performed. Please understand that, in some rare cases, there may be unusual circumstances, unexpected conditions or complications that require additional services to be performed. These additional services may result in additional charges. **These additional charges may or may not be covered by your insurance.**

Signing below means that you have received and understand this notice and agree to pay your designated amount(s) as described within it. You will also receive a copy of the signed notice.

Signature: _____ Date: _____