SANTÉ PHYSICIANS

WAIVER OF LIABILITY FORM

MEMBER NAME: _____ DOB: _____

SUBSCRIBER ID: _____ GROUP NO: _____

PROVIDER: _____

Provider: This form is to be use for HMO members who wish to receive health care services from you that may not be covered by the member's insurance.

Member: Your signature on this form acknowledges that you agree to bear financial responsibility for all services provided as listed below if:

- the service(s) is not covered under your benefit plan, or,
- the service(s) has not been otherwise approved for payment by your health plan, or
- the service(s) is not medically necessary, or
- the service(s) is primarily for comfort and convenience, or,
- You choose to upgrade a product or service above the level otherwise covered under your health plan (you will pay the difference between the billed and allowed amount)

Services: (Any service not described as a covered benefit in the member's Evidence of Coverage Disclosure Form)

Date of Service	Service, Product or Upgrade	Total Cost	Member's (patient's) Responsibility

*In addition to being responsible for this amount, I understand that I will responsible for any applicable copayment or deductible.

_____
Patient Name

_____ _____
Signature of Patient/Guardian Date

_____ _____
Signature of Witness Date

June 1, 2021