Humana Military

TRICARE

TRICARE NONCOVERED SERVICES WAIVER

Date:_____

Sponsor Name:_____ Sponsor ID:_____

Patient Name:_____ Patient ID: _____

Service Description

Procedure: _____

_____

Approximate Cost:_____

Diagnosis: _____

_____

Date of Service: _____

Provider Name: Austin Springs Women's Health / Martha Schmitz, MD Barbara Howard, WHNP-BC APRN

TIN: 52-2388793 Group NPI: 1114933959

Address: 4007 James Casey Suite A240 Austin, Texas 78745

Phone: 512-394-0054 Fax: 833-907-0579

Physician Signature:_____

I hereby affirm that I have been informed and I understand that these services are excluded or excludable under the TRICARE Program and therefore all costs associated with these services are not an allowable expense under The TRICARE Program. By signing the TRICARE noncovered services waiver, I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with the noncovered medical services, described in this document under **"Service Description"** and performed by the named TRICARE Network Provider.

Patient Signature:_____ Date:_____

Beneficiary's or Legal Guardian's Signature:_____ Date:_____

Witness Signature:_____ Date: _____

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002
CHAPTER 5, SECTION 1

2.5.1. A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e. the beneficiary will be held harmless) except as follows:

- If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary, the provider may bill the beneficiary for services provided.
- If the beneficiary was informed that the services were excluded or excludable and he/she agreed in advance in writing to pay for the services, the provider may bill the beneficiary. An agreement to pay must be evidenced by the written consent of the beneficiary to pay for the excluded services. General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or excludable.
- If the beneficiary has been notified, in writing, that the service would not be covered for any reason.

For a list of excluded or excludable services refer to:
TRICARE POLICY MANUAL 6010.54-M, August 1, 2002 CHAPTER 1 SECTION 1.1
ISSUE DATE: June 1, 1999 AUTHORITY: 32 CFR 199.4(g)