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INSURANCE DISCLAIMER

We try our best to find out what your insurance coverage will be for services in our office. However, there are hundreds of policies and thousands of clauses that can change what your final bill will be. As a courtesy, we provide estimates based on the information that we have received but it is ultimately your responsibility to know what your insurance will cover and how often they will cover services. If you have a balance on your account after insurance has paid, **IT IS YOUR RESPONSIBILITY TO PAY YOUR REMAINING BALANCE.**

Patient Name: _____

Date: _____

Signature: _____

*Minnesota Health Care Programs (MHCP)***Advance Recipient Notice of Non-covered Service/Item**

MHCP does not pay for everything, even some services or items that you or your health care provider has good reason to think you need. MHCP does not pay for the **non-covered service/item** listed below. Your health care provider is allowed to charge you and you will have to pay if you choose to get this service or item. Before signing this form:

- Read this notice and the instructions so you can make an informed choice about your care
- Ask your health care provider any questions that you may have

Provider: Print both pages of this form; keep one copy in recipient file, give one copy to recipient.

Recipient Information

RECIPIENT LAST NAME	FIRST NAME	MI	MHCP RECIPIENT ID #	DATE OF BIRTH
Non-covered service/item - description (and code, if available)	Services outside of provider contract			
Reason(s) service/item is not covered by MHCP	Contract may not pay for some services			
Alternate covered service(s)/item(s)	Spinal Manipulation, Spinal X-Rays, Acupuncture for pain management.			
Estimated cost of non-covered service/item	Starting at @20.00			
Terms of payment	Due at time of service			

Recipient Signature – Read the statement below, check the box if you understand and agree, sign and date.

☐ I want the non-covered service/item listed above. I understand that: ■ The service or item is not covered by MHCP ■ I will have to pay for the service or item listed above ■ A different service or item may be covered by MHCP and I do not want that service or item ■ The provider may have asked for authorization and the authorization was denied ■ The provider will not bill MHCP for a service or item never covered by MHCP and I cannot appeal if MHCP is not billed ■ If the item requires repair, I will have to pay for the repair		
SIGNATURE – RECIPIENT OR LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/RESPONSIBLE PARTY	DATE	LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE/RESPONSIBLE PARTY NAME (Please print)

Provider Signature

Individual Providers – If you were the person who explained this form and discussed available options, complete:

- Individual Provider Name
- Individual NPI/UMPI
- Individual Provider Signature/Date fields

Group Providers – If someone within your organization explained this form and discussed available options, use your group NPI and have the health care representative (assistant, patient care coordinator, etc.) complete:

- Group Provider Name
- Group NPI/UMPI
- Authorized Healthcare Representative Signature/Date fields, signed by the facility's designated representative

INDIVIDUAL PROVIDER NAME Multiple Providers: DC, LAc	INDIVIDUAL NPI/UMPI On File	INDIVIDUAL PROVIDER SIGNATURE	DATE 1/1/2025
GROUP PROVIDER NAME Comprehensive Health Clinics	GROUP NPI/UMPI 1083785679	AUTHORIZED HEALTHCARE REPRESENTATIVE SIGNATURE	DATE 1/1/2025