envolve
VISION BENEFITS | Puerto Rico

NON-COVERED SERVICES LIABILITY ACKNOWLEDGEMENT

Member Name: _____

Member ID#: _____

Health Plan: _____

Provider Name: _____

Provider Address: _____

Date of Service: _____

I (the member or if a minor, guardian of the member as listed above) acknowledge that it has been explained to me that certain health care services (s) or supplies that I have requested or wish to purchase will not be covered under the terms of my Health Plan benefit schedule. The non-covered services(s) that I have requested are:

_____

_____

_____

I also acknowledge that I have been advised that these services are optional and as such, I will be responsible for payment for these non-covered services and agree to make arrangements with the Provider for such payment, directly to the Provider of these services.

_____
Member/Guardian Responsible for Payment

_____
Member/Guardian Signature

_____
Date Signed

Signed copy should be maintained in Member's medical records