THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER
AT DALLAS

Ambulatory Services
Department of Medical Records

Waiver of Liability
Commercial/Managed Care

Pt. Name:____________________________
Address:____________________________
____
City State Zip
MRN: ____________________________
DOB: ____________________________
SSN: ____________________SEX:______
DOS: ____________________________

Physician Notice:

Your health plan has indicated that the service(s) listed below are not covered services, therefore there are no plan benefits for the service(s). Your health plan is likely to deny payment for ____ for the following
specify particular service using, procedure code and description

reason: ____.
give reason(s) for denial

Patient Agreement:

I have been notified by my physician that he or she believes that, in my case, ____________________________ is likely to deny payment for the services identified above. I agree to assume financial responsibility for the service(s).

Signed,

____________________________________ ____________________________
Signature of patient or person acting on patient's behalf Date

____________________________________ ____________________________
Signature of person who explained waiver of liability Date

The non-covered services may include separate bills for a hospital fee as well as a physician fee for the services rendered.

Form # AMA/WOLCMC-01 / 11.01

CONSENTS / FINANCIAL