(Customize top of form with name, address & phone) *(Provide 1 copy to patient; keep original in your files.)*

Patient's Name:

Notice of Exclusion from Health Plan Benefits

Health insurance does not pay for all of your health care costs. Insurance only pays for covered benefits. Some items and services are not insurance benefits and your insurance plan will not pay for them. When you receive an item or service that is not a covered benefit, you are responsible to pay for it, personally or through any other insurance that you may have. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully. Ask us to explain, if you don't understand why your insurance won't pay.

Your doctor has recommended:
Photorefractive keratectomy (PRK). PRK is a type of eye surgery performed with a laser for the purpose of correcting refractive errors and reducing dependency on eyeglasses or contact lenses.

Your health plan will not pay for:
Cosmetic refractive surgery such as PRK because it does not meet the definition of any covered benefit.

Your health plan will only pay for:
Medically necessary procedures for the treatment of disease, injury or malformation.

Your are responsible for:
All of the fees associated with a non-covered service including the surgeon's professional fee $_____ and the charge for the ASC or hospital facility fee $_____.

Beneficiary Agreement

Accordingly, the undersigned accepts full financial responsibility for the non-covered services described above.

_____ _____

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