MERCYONE

Beneficiary Liability Form (Waiver of Non-Covered Services)

***Not to be used for Medicare, Tricare or Medicaid**

Patient Name (please print): _____ Date of Birth _____

Physician/Provider Name (please print): _____

Date of Service (collection): _____

My healthcare provider has explained the tests listed below as they relate to management of my condition. I understand that the testing may be considered not medically necessary, experimental or investigational by my health insurance policy or coverage manual and therefore, may not be covered by my health insurance benefits.

Test Name	CPT Code	Price
Focused Pharmacogenomics Panel (PGXQP)	0029U; and if appropriate 0071U, 0072U, 0073U, 0074U, 0075U and 0076U	$315.00

I agree to be financially responsible for these services should my insurance plan deny coverage.

Patient Signature _____ Date _____

Provider/Clinical Staff Signature _____