FULCRUM HEALTH

Provider Name: _____

Provider Address: _____

Provider Phone: _____

Non-Covered Services: Financial Disclosure Form (Medicare Advantage)

Your health care coverage may not cover all items or services requested by you or your provider. As part of your treatment plan, your provider will discuss the coverage and costs of any non-covered items/services, including those no longer considered medically necessary (also known as Maintenance/Wellness Care). Your health care provider may charge you for non-covered items/services should you choose to accept them. 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.

I, _____ *(patient's name)* understand the following items/services are not expected to be covered or have been denied by my health plan. Nonetheless, I agree to accept them and agree to pay the charge(s) for the following service(s):

Treatment Start Date: _____ *Treatment End Date: _____

***Note: A new Financial Disclosure Form must be reviewed and signed with the patient every 12 weeks for care not covered under their plan, for elective care after a new acute episode that has achieved maximum therapeutic benefit (even if it is within a previous 12-week period). Form must be signed prior to rendering non-covered items/services. Failure to fill out this form in its entirety will make the form invalid and charges will be provider liable.**

Non-Covered Chiropractic Service	Reason Item/Service is not covered	Cost per Visit	Patient Initials
Exam(s)			
Manipulation (for maintenance care or wellness)			
X-Ray(s)			
Therapies/Modalities (circle all that apply) Electric Stimulation Acupuncture Ultrasound Exercise Education Other_____			
Durable Medical Equipment (circle all that apply) Braces Orthotics Ice pack Other: _____			
Massage			
Other (specific)			
TOTAL COST:			

I acknowledge that I am signing this statement voluntarily, and that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patient/Authorized Representative Signature: _____Date: _____

Provider/Clinic Administrator Signature: _____ Date: _____

Note to Provider: All fields above must be entered accurately and completely, including dates, costs, and reason why services are not covered. The patient must acknowledge each non-covered line with their initials to be considered valid.

Addition for Medicare Advantage Patients: Providers must request an Organization Determination for any non-covered items/services for which Fulcrum will issue a determination. Only following an adverse determination can this form be used. Forms dated prior to a Fulcrum denial, or after services have been rendered, will make the form invalid and charges will be provider liable.

This form is based on requirements detailed in Fulcrum's Noncovered Services Policy NM007, available on ChiroCare.com xxxxx