



Employee Assistance Program  
Toll Free: 800.731.6501  
Telephone: 574.232.2131  
Fax: 574.271.5980

Midwest Behavioral Health Network  
Toll Free: 800.223.6246  
Telephone: 574.271.5177  
Fax: 574.271.5980

### CONSENT TO PAY FOR NON-COVERED SERVICES

Patient's Name: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

I understand that my insurer will not pay for services that it determines are not medically necessary. My provider has advised me that my insurer is likely to deny payment for the following services:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

for the following reasons:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If my insurer denies payment for the services identified above, then I agree to be personally and fully responsible for the payment. **BY SIGNING THIS FORM, I UNDERSTAND THAT I AM AGREEING TO PAY FOR THE SERVICES IDENTIFIED ABOVE IF MY INSURER DENIES PAYMENT BECAUSE THE SERVICES ARE NOT MEDICALLY NECESSARY.**

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date