



## TRICARE Beneficiary Liability Form (Waiver of Non-Covered Services)

Active Duty Service Members Cannot Waive or be Billed for Non-Covered Services

This waiver allows a network (contracted) provider to collect billed charges for services denied as 'non-covered' (not a TRICARE benefit) from a TRICARE beneficiary when the beneficiary has agreed, in writing, to waive his or her balance-billing protection.

I, \_\_\_\_\_, the TRICARE beneficiary, hereby agree to pay the full billed charge(s) for the following service(s) if such service is subsequently denied as non-covered (not a TRICARE benefit) regardless of the fact the TRICARE program will not make payment:

Date: \_\_\_\_\_ Service (Code): \_\_\_\_\_ [Estimated] Billed Charge: \_\_\_\_\_

Date: \_\_\_\_\_ Service (Code): \_\_\_\_\_ [Estimated] Billed Charge: \_\_\_\_\_

Date: \_\_\_\_\_ Service (Code): \_\_\_\_\_ [Estimated] Billed Charge: \_\_\_\_\_

TOTAL [ESTIMATED] BILLED CHARGES: \_\_\_\_\_

**Note:** This waiver applies to any and all TRICARE non-covered services indicated above rendered by this provider, including, but not limited to office visits, office procedures, hospital visits, and surgical fees.

**I acknowledge that I am signing this statement voluntarily, and that it is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) for any services denied as non-covered (not a covered TRICARE benefit) and listed above and will pay the provider this amount, regardless of the fact TRICARE will not make payment. I also understand that it is my choice to have these services provided at a future date and time by this provider .**

TRICARE BENEFICIARY SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

TRICARE BENEFICIARY NAME (PRINTED) \_\_\_\_\_

SPONSOR SSN \_\_\_\_\_ RELATIONSHIP TO SPONSOR \_\_\_\_\_

Providers must follow all applicable coding regulations. If an appropriate CPT code exists that covers several procedures rendered, the provider must use the all-inclusive procedure code and not bill for each procedure separately.

### PROVIDER INFORMATION

NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE NUMBER ( \_\_\_\_\_ ) \_\_\_\_\_

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