365 DME
9860 Hudson Road • Pittsford, MI 49271
Phone: 517-997-5938 • Fax: 855-978-1450

COMMERCIAL INSURANCE WAIVER OF LIABILITY

Customer Name: _____ **Customer ID:** _____

The medical equipment/supply delivered to you may not be paid by your insurance carrier for the reason/s checked below. If your insurance carrier denies our claim, you agree to be personally and fully responsible for payment.

Delivery Date:	**Item & Description:**
___/___/___	_____
___/___/___	_____
___/___/___	_____
___/___/___	_____

Possible reason/s for a denied claim:

- ☐ The services are not reasonable and medically necessary for the diagnosis or treatment of illness or injury.
- ☐ A same or similar item may have been previously delivered and billed.
- ☐ An authorization may be required before delivery.
- ☐ A Predetermination may be required before delivery.
- ☐ A Primary Care Physician referral is required and has not been made by the PCP yet - if not made then you will be responsible.
- ☐ My insurance benefits could not be verified for coverage or determination prior to delivery.
- ☐ I have elected to receive an item deemed to be “deluxe” in nature.
- ☐ My insurance requires test results to verify coverage criteria and they are not available prior to delivery.
- ☐ This item is typically not covered by insurance.
- ☐ My Medicaid spend-down has not been met. I am paying today so I can apply this to my spend-down.
- ☐ Other: _____

_____

_____

Beneficiary Agreement:

I have been notified by my supplier that he or she believes that in my case, my insurance carrier is likely to deny payment for the services identified above, for the reasons stated above. If my insurance plan/s deny payment, I agree to be personally and fully responsible for payment.

_____ ___/___/___
Patient Signature (or responsible party) Date