UNIVERSITY OF GEORGIA
University Health Center
Student Affairs

Division of Student Affairs
55 Carlton Street
Athens, Georgia 30602
TEL 706-542-1162 | FAX 706-542-8652
contact@uhs.uga.edu
uhs.uga.edu

NAME: _____

UGA ID#: _____

Date of Birth: _____

ABN TRICARE AND COMMERCIAL INSURANCES

This waiver allows a network (contracted) provider to collect billed charges for services denied as 'non-covered' from beneficiary when the beneficiary has agreed, in writing, to waive his or her balance-billing protection.

I,_____, the TRICARE or other COMMERCIAL INSURANCE beneficiary, hereby agree to pay up to the full billed charge(s) for the following service(s) if such service is subsequently denied as non-covered regardless of the fact the TRICARE or other COMMERCIAL INSURANCE program will not make payment:

Service Code: 97161	Estimated Charges: $97
Service Code: 97162	Estimated Charges: $97
Service Code: 97163	Estimated Charges: $97
Service Code: 97110	Estimated Charges: $33-$135
Service Code: 97112	Estimated Charges: $33-$135
Service Code: 97140	Estimated Charges: $33-$135
Service Code: 97530	Estimated Charges: $33-$135
Service Code: 98966	Estimated Charges: $30
Service Code: 98967	Estimated Charges: $45
Service Code: 98968	Estimated Charges: $60

TOTAL [ESTIMATED] BILLED CHARGES for an individual session: $30-$135

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

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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 and listed above and will pay the provider this amount, regardless of the fact TRICARE or other COMMERCIAL INSURANCE 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.

BENEFICIARY SIGNATURE:_____DATE: _____

BENEFICIARY NAME: (PRINTED) _____

This form is valid from:

TODAY'S DATE: _____ through DATE ONE YEAR FROM TODAY: _____

INSURED (MEMBER) ID*:_____RELATIONSHIP TO INSURED**: _____

*Your member ID is the list of letters and numbers on your insurance card that uniquely identifies your health plan

**Your relationship to the person who is the main health insurance policy holder (ex. Child, spouse, self)

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: University Health Center, University of Georgia

ADDRESS: 55 Carlton Street

CITY: Athens STATE: GA ZIP CODE: 30602 PHONE NUMBER: 706-542-8621

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**Once you have completed this form, please save and upload to your UHC patient portal. The link to the portal can be found as a main heading on the UHC website. You will need to login to the portal using your UGA MyID and PW. Then, click "Immunization Upload" on the bottom left hand side of the screen. Click "Add Immunization Record" and upload this completed and saved document there.