NEW YORK GASTROENTEROLOGY ASSOCIATES

Waiver Form For:

- Non Covered Services
- Not Medically Necessary Services
- Experimental/Investigational Services

Waiver Form Statement

The purpose of this waiver form is to inform NYGA patients before they receive a medical service, that the service listed below may not be considered medically necessary and therefore may not be covered by your insurance carrier. By signing this form, I, the physician acknowledge and agree that I have explained to the member that the service(s) listed may not covered.

Benefits that may have been exceeded, exhausted or are excluded by the patients insurance carrier or are considered not medically necessary or investigational, are the member's responsibility.

I have been informed by the provider (listed below) in advance that the service(s) listed below are services that may not be covered under my member contract. I understand and agree that I am responsible for payment of the provider's charges for these services to the provider of service should they not be covered by my carrier.

Service(s) To Be Provided

	Procedure/Service	Procedure Code
☐	Smart Pill	91112
☐	Pill Cam	91110
☐	Esophageal Manometry	91010
☐	Anorectal Manometry	91122 & 91120
☐	Ph Impedence	91037 & 91098
☐	Nutrition Visit	97802 / 97083

Date ___/___/_____

I. Provider Information

Physician Name:_____

Physician Signature:_____

II. Patient Information DOB____/____/____

Patient Name:_____

Patient Signature:_____