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Non-Covered Service Waiver Form

For the Member

I understand that I am responsible for all the costs associated with the procedure/item listed below. My provider has informed me that my insurance does not pay for this procedure/item because:

- The procedure or item is not considered medically necessary
- It is not a covered benefit under my plan
- He/she is not contracted to perform/provide this procedure/item
- Other _____

* Member name: _____

* Member ID (include alpha prefix): _____

* Member Signature: _____ Date: _____

For the Provider

As a participating Insurance Provider, I certify that I have informed my patient, _____
That the insurance listed above does not allow payment for the procedure/item listed below
because:

- The procedure or item is not considered medically necessary
- It is not a covered benefit under my plan
- He/she is not contracted to perform/provide this procedure/item
- Other _____

Procedure/Item:	Procedure code:
Phone Follow Up Visit with Chart Note	99442/ 99443

Provider Name: Kimberly A Iller, ND LAc

Provider Signature: _____ Date: _____