

[Date]
[Patient Name]
[Patient Address]
[City, State, Zip Code]

Subject: Notice of Non-Coverage for Routine Maintenance Care

Dear [Patient Name],

This letter is to inform you that the services scheduled for [Date of Service] are considered **Routine Maintenance Care** and are not covered under your current health insurance plan with [Insurance Company Name].

Maintenance care consists of treatment services that are intended to maintain an optimal level of health or prevent regression for a condition that is stable or chronic. According to your insurance provider's guidelines, coverage is only provided for "Active Treatment" where there is an expectation of significant functional improvement.

Financial Responsibility:

Since these services are not covered by your insurance provider, you will be responsible for the full cost of the visit. The estimated cost for this service is \$[Amount].

If you wish to proceed with the treatment, please sign below to acknowledge that you have been informed of the non-coverage and agree to accept financial responsibility.

If you have any questions regarding your benefits, we recommend contacting [Insurance Company Name] member services directly.

Sincerely,

[Provider/Office Name]
[Phone Number]

Patient Acknowledgment:

I understand that the treatment I receive today is considered maintenance care and will not be covered by my insurance. I agree to pay for these services out-of-pocket.

Signature of Patient or Guardian

Date