

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Member ID: [Insert Member ID]

Provider Name: [Insert Provider Name]

Subject: Statutory Non-Covered Services Notification

Dear [Patient Name],

This letter is to inform you that the following service(s) or procedure(s) recommended for your care are considered "Statutory Non-Covered Services" under your current health insurance benefit plan:

- **Service/Procedure:** [Insert Service Name]
- **Estimated Cost:** [Insert Amount]
- **Proposed Date of Service:** [Insert Date]

Reason for Non-Coverage:

The service(s) listed above are specifically excluded from coverage by your health plan's summary of benefits. This exclusion is based on the statutory limitations of your policy and is not a determination of medical necessity.

Financial Responsibility:

Because these services are not covered by your insurance plan, you will be personally responsible for the full payment of the charges incurred. Payment arrangements must be made with our office prior to or at the time the service is rendered.

Acknowledgment:

By signing below, you acknowledge that you have been notified in advance that these services are not covered by your insurance and that you agree to accept full financial responsibility for the total cost.

Patient/Guarantor Signature

Date

If you have questions regarding your plan benefits or why these services are excluded, please contact your insurance provider's member services department at the number listed on your ID card.

Sincerely,

[Authorized Signature]
[Title]
[Facility/Practice Name]