Anthem
*Decide to be healthy.*SM

WAIVER FORM FOR

- **NON-REFERRED SERVICE**
- **NOT MEDICALLY NECESSARY SERVICE**
- **EXPERIMENTAL/INVESTIGATIVE SERVICE**

I. Provider Information

Provider Name: Brett M. Coapland, DC, CSCS
Kanoa Pornelos-King, DC, MS

Practice Name: Performance Health

Phone: (603) 724-2297

Provider Number: 1518090984, 1902294036, 1205100096

II. Patient Information

Patient Name: _____

Patient ID#: _____
(Prefix) (Suffix)

DOB: ____/____/____ Sex: M F

III. Waiver Form Statement and Provider Signature

The purpose of this waiver form is to inform Anthem Blue Cross and Blue Shield (Anthem BCBS) members, before they receive a medical service, that the service listed below is non-referred or not medically necessary or experimental/investigative. By signing this form, I, the provider acknowledge and agree that I have explained to the member that the service(s) listed are not a covered service(s).

_____ _____
(Provider Signature) (Date)

IV. Reason for Waiver Form

☐ **Non-Referred Service**

HMO Members—Non-referred services are not covered by Anthem BCBS and, therefore, are the member's responsibility.

Patient Signature

I have been informed by the provider indicated in Section I. in advance that the service(s) listed below are services that have not been referred by my primary care provider and are not covered. I understand and agree that I am responsible for payment of the provider's charges for these services to the provider of service.

Patient Signature: _____
Date: _____

☐ **Not Medically Necessary Service**
☒ **Experimental/Investigative Service**

Not medically necessary and experimental/investigative services are not covered by Anthem BCBS and, therefore, are the member's responsibility.

Patient Signature

I have been informed by the provider indicated in Section I. in advance that the service(s) listed below are services that are not medically necessary or are services that are experimental/investigative and are not covered. I understand and agree that I am responsible for payment of the provider's charges for these services to the provider of service.

Patient Signature: _____
Date: _____

V. Service(s) To Be Provided

Date(s) of Service	Procedure/Service	Procedure Code*	Amount Charged
____/____/____	Active Release Techniques (ART)		$20
____/____/____	Trigger Point Dry Needling (TDN)		$0
____/____/____			
____/____/____			

*If applicable