Executive Health Program
10 Plum Street, 8th Floor
New Brunswick, NJ 08901

Date:_____
Patient Name:_____
Patient Date of Birth:_____
Provider Name:_____

Non- Covered Service/ Item Waiver

There are items and services for which your Health Plan will not pay. Your Health Plan does not pay for all of your health care costs, but only pays for covered benefits. When you receive an item or service that is not a covered benefit under your Health Plan, you will be responsible for payment, personally or through any other insurance that you may have.

The purpose of this Waiver is to assist you to make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you may want to contact your Health Plan to determine whether a particular item or service is a Covered Benefit.**

The Robert Wood Johnson University Hospital ("RWJUH") Executive Health Program charges a convenience fee of seven-hundred dollars ($700) to all participants. This fee is likely to be considered a Non-Covered Benefit by your Health Plan, despite the fact that RWJUH may be a Network Provider for your Health Plan. By signing this Non-Covered Service Waiver form, you agree to waive your balance billing protection that might otherwise apply under the terms of your Health Plan and consent to RWJUH collecting billed charges for Non-Covered services from you.

By voluntarily signing this Non-Covered Service/Item Waiver form ***prior to the provision of any item or service by RWJUH Executive Health***, I acknowledge that if any item or service as noted below is deemed Non-Covered by my Health Plan for any reason, including a determination of not Medically Necessary, I agree to be financially responsible to RWJUH for either the full amount or the balance after payment by the Health Plan, should the Claim be denied or processed at a lesser Benefit level.

DATE: _____ Service (Code):990_____ Estimated Billed Charge: ____$700_____
DATE: _____ Service (Code):_____ Estimated Billed Charge: _____
DATE: _____ Service (Code):_____ Estimated Billed Charge: _____

Total (Estimated) Billed Charges: _____

Health Plan Beneficiary Signature:_____
Date: [must be prior to the provision of noted item(s) or service(s)]_____
Health Plan Beneficiary Name (Printed):_____

Provider Information

Name: Robert Wood Johnson University Hospital Executive Health Program
Address: 10 Plum Street ___
City: New Brunswick State: New Jersey ZIP code: 09801
Phone Number: (732) 253-3690