

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER
AT DALLAS

Ambulatory Services
Department of Medical Records

**Waiver of Liability
Medicaid**

Pt. Name: _____
Address: _____

City State Zip
MRN: _____
DOB: _____
SSN: _____ SEX: _____
DOS: _____

Physician Notice:

If Medicaid determines that a particular service is not a covered service, Medicaid will deny payment for that service. In your case, Medicaid is likely to

deny payment for _____ for the following
specify particular service

reasons: _____
give your reason(s) for your belief

Patient Agreement:

I understand that, in the opinion of _____ the services or items
provider's name

that I have requested to be provided to me on _____ may not be covered
provider's name

under the Texas Medical Assistance Program. I understand that I am responsible for payment of the services or items I request and receive if these services or items are non-covered services under the Texas Medical Assistance Program.

Signed,

Signature of patient or person acting on patient's behalf

Date

Signature of person explaining waiver of liability

Date

The non-covered services may include separate bills for a hospital fee as well as a physician fee for the services rendered.