



Service Waiver/ Patient's Liability Agreement Commercial Insurance & Medicare Advantage

Patient Name: _____ Chart #: _____ Date: _____

Provider: _____ Department: _____

By signing below, I acknowledge and agree to the following:

- I confirm that I do **not** have original/traditional Medicare.
- I have been informed by the provider or Boulder Medical Center staff that the item(s) listed below may be reimbursed by my insurance carrier at a reduced rate or not at all, resulting in a balance for which I am personally responsible.
- I understand that Boulder Medical Center providers may not be contracted with my insurance carrier and/or these Item(s) may not be a benefit of my insurance plan, resulting in a balance for which I am personally responsible.
- I understand that a diagnosis of medical necessity by my provider does not mean that my health plan will pay for the services listed, resulting in a balance for which I am personally responsible.
- I understand that once an injection is prepared, the cost of the injection is my responsibility, even if the injection is refused or cannot be given.

Code(s)	Description of Code(s)	Charge (fee)	Unit	Today's Charges
90480	Administration Fee	\$70.00		
91320	Covid Pfizer 12 years up	\$200.00		
91319	Covid – Pfizer 5 – 11 years	\$ 135.00		