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INSURANCE WAIVER FOR NON-COVERED SERVICES

Dear Patient:

You have been scheduled for a **SCREENING** colonoscopy. Payable benefits for screening procedures varies drastically among insurance companies. Therefore, **we strongly encourage you to call your insurance carrier to verify your specific benefits.** Being informed in advance will help prevent any unexpected financial obligations you may incur.

Please follow the instructions below and, if you have ANY questions, please call our billing department at (586) 286-5400, ext. 109 or ext. 110.

1. Call the customer service phone number (usually listed on the back of the insurance card).
2. Check your benefits for both **SCREENING** and **DIAGNOSTIC** colonoscopy.
 - a) Ask if **screening** colonoscopy is a covered benefit:
Procedure (CPT) code: **G0105** and/or **45378**
Diagnosis code: **V76.51** (screening for malignancy surveillance)
 - b) Ask if **diagnostic** colonoscopy is a covered benefit (i.e., if a colon polyp were found/removed, would you be subject to a deductible and/or copay).
Procedure (CPT) code: **45378**
Diagnosis code: **211.3** (colon polyp)

Please sign the agreement below and return it to our office as soon as possible. We must receive this signed form **at least 3 business days prior** to your appointment date or your procedure may be cancelled.

PATIENT AGREEMENT	
I have been informed by Tri-County Gastroenterology, PC (physician and/or staff) that my insurance may deny payment for the service identified above. If my insurance company denies payment, I agree to be personally and fully responsible for payment of the service rendered.	

Patient Name (please print)	
_____	_____
Patient Signature	Date
_____	_____
Witness Signature	Date