Advantra Member Authorization to Perform Non-Covered Services

I have requested that my Provider, _____ (Name), furnish me with the following services:

_____

_____

_____

_____

My Provider has informed me that the services listed above are not covered under my Advantra Evidence of Coverage. My signature below indicates that I agree to accept responsibility for payment for such non-covered services and hold harmless Advantra and Coventry Health Care of Georgia, Inc. for such payment.

_____ _____

SIGNATURE OF PATIENT DATE

_____

PRINTED NAME OF PATIENT