

**BLUE CROSS BLUE SHIELD
PATIENTS ONLY**

Dear Patient:

We are asking you to sign this Non-Covered Services form because there is a possibility that your insurance may not cover **lab, mammogram, bone density** and/or **ultrasound** services. Every contract is different. If your insurance does not cover one of these services that your physician orders, you will receive a bill.

Date

Signature

Date of Birth

Patient ID #