PASSPORT
BY MOLINA HEALTHCARE

Non-Covered Services Disclosure Form

To be completed by the provider

I am recommending that _____ receive services
Member Name and Identification Number
that are not covered by the Molina Covered Benefits Schedule. I am willing to accept my Usual and Customary Fee as payment in full. The following procedure codes are recommended:

CODE	DESCRIPTION	FEES

The total amount due for service(s) to be rendered is $

Doctor's Signature *Date*

To be completed by Member

I _____, have been told that I require
Print Your Name
services or have requested services that are not covered by the Molina Covered Benefits Schedule.

Covered Benefits Schedule.

Read the question and check either YES or NO	YES	NO
My doctor has assured me that there are no other covered benefits.	☐	☐
I am willing to receive services not covered by my Health Plan	☐	☐
I am aware that I am financially responsible for paying for these services.	☐	☐
I am aware that my Health Plan is not paying for these services.	☐	☐

I agree to pay $ _____ per month. If I fail to make this payment, I may be subject to collection action.

Member's Signature if over eighteen (18) or Parent / Guardian *Date*