Anesthesia Associates of Southwest Florida, LLC

1220 E. Venice Ave.
Venice, FL 34285
941.484.5000
Fax 941.484.4414

Aetna Non-Covered Service Waiver

Provider notice to Aetna member regarding non-covered services that may not be paid by Aetna. The procedure listed below may not be paid by Aetna. We are instructed to bill the Aetna member as noted in the excerpt below.

Anesthesia Services (ASA Class I)

May be a non-covered service; total to be paid by member may be $305.00

3.2 Billing of Members. Under certain Plans, Members may be required to pay Copayments, Coinsurance or Deductibles for certain Covered Services. Facility shall collect any applicable Copayments, Coinsurance and Deductibles from Members. Copayments shall be collected at the time that Covered Services are rendered. Except for applicable Copayments, Coinsurance and Deductibles, **Facility may bill Members only in the circumstances described below.**

3.2.1 If the applicable Payor is not a health maintenance organization ("HMO"), Facility may bill a Member for Facility Services provided to the Member in the event that the Payor becomes insolvent or otherwise breaches the terms and conditions of its agreement to pay, provided that: (a) Facility shall have first exhausted all reasonable efforts to obtain payment from the Payor; and (b) Facility shall not institute or maintain any collection activities or proceed with any action at law or in equity against a Member to collect any sums that are owed by a Payor to Facility unless Facility provides at least thirty (30) days prior notice to Company of Facility's intent to institute such an action.

3.2.2 Subject to Company's rules, policies and procedures services that are not Covered Services may be billed to Members by Facility only if: (a) the Member's Plan provides and/or Company confirms that the services are not covered; (b) the Member was advised in writing prior to the services being rendered that the specific services are not Covered Services; and (c) the Member agreed in writing to pay for such services.

I have been notified that my service or a portion of my services may be a non-covered procedure and I agree to pay the above amount to Anesthesia Associates of Southwest Florida.

Aetna Member's signature:____

Date:____________________________ Witness:____________________________

Accredited by

Accreditation Association for Ambulatory Health Care, Inc.