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Pacific Eye
HMO Waiver Form

Date: _____/_____/_____

Patient Name:_____

Services may not be covered by your insurance plan, _____, unless prior authorization is obtained.

If you would like for us to provide you with the service today without an authorization, please sign below.

I understand that my HMO plan may not pay for unauthorized services. If my visit is denied for no authorization, I agree to be financially liable.

_____ _____
Signature Date

_____
Relationship to patient (If patient is a minor)