# Pre-Service Payment Consent Form

This form is *only* for Medica members in employer-based health plans and individual and family health plans.

**Member Name:** _____

**Medica Member ID Number:** _____

**Provider Name:** _____

**National Provider Identifier (NPI) Number:** _____

**Date(s) of Service:** _____

**Description of specific service(s) and reason service is not a covered benefit:**

_____
_____
_____
_____
_____
_____

I understand that the services described above may not be covered by Medica. By signing this form, I know that I may have to pay for these services if Medica does not cover them. I also understand that I have the right to appeal a coverage decision that Medica makes if I disagree with it.

**Member Signature**: **Date**:

_____ _____

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