



TRICARE PRIME PUERTO RICO
TRICARE NON-COVERED SERVICES WAIVER FORM

NOTE: Please have provider confirm service is non-covered

I hereby agree to accept full financial responsibility for the following medical care received from which is a non-covered service based on my current TRICARE benefits according to government policy.

SERVICE DESCRIPTION

These non-covered services will be rendered to on (Patient's Social Security Number) (Name of TRICARE patient) (Sponsor's Social Security Number)

Beneficiary's or Legal Guardian's Signature

Signature Date



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