



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

Three horizontal lines for service description.

These non-covered services will be rendered to _____, on _____.

Beneficiary's or Legal Guardian's Signature Signature Date



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