Tampa Bay Uveitis Center, LLC
303 Main Street, #764
Safety Harbor, FL 34695
(855) RX - UVEYE
(888) 539 - 6488

Limited Insurance Benefit Notification Form

Date of Service: _____

Patient Name: _____

Service Description and CPT Code:

_____

_____

_____**Cost:** _____

I hereby acknowledge that I have been informed and understand that the above services may not be covered or are a non-covered expense under my insurance policy. By signing this Limited Insurance Benefit Notification Form, I am hereby agree in advance to accept full financial responsibility for all costs associated with the above described service in this document under "Service description".

_____ _____

Patient (or person authorized to sign for patient) **Date**

_____ _____

Witness **Date**