



500 Patroon Creek Blvd. • Albany, NY 12206-1057 • (518) 641-3700

SPECIALIST PATIENT TREATMENT WAIVER

I, _____, _____,
(MEMBER NAME) (MEMBER ID NUMBER)

am a CDPHP member who is requesting treatment from _____,
(PROVIDER'S NAME)

without the required referral/authorization number from my CDPHP primary care physician. As a result, I agree that I shall be responsible for payment in full for any charges related to services provided to me or my dependent at this office if I fail to provide the specialist with a referral/authorization that was issued timely.

Signed: _____

Date: _____

Witnessed: _____

This waiver is being used to ensure the integrity and purpose of the primary care physician referral/authorization process.