

**MILLENNIUM FAMILY PRACTICE  
9055 CHEVROLET DRIVE,  
SUITE 100  
ELLCOTT CITY, MD 21042  
TEL: 410.313.9662 FAX: 410.313.9664**

**DATE:** \_\_\_\_\_

**I, \_\_\_\_\_ agree to pay Millennium Family Practice for medical services rendered if any insurance company does not pay for CPT 82948 Glucose Blood Reagent Strip. I understand that I will be reimbursed by my insurance company if they decide to pay Millennium family Practice for services rendered.**

\_\_\_\_\_  
**(Patient's Name)**

\_\_\_\_\_  
**(Date)**