OUT-OF-NETWORK NOTICE & DISCLOSURE

I, ____________________, (PATIENT/ENROLLEE NAME) HAVE BEEN INFORMED OF AND RECEIVED A COPY OF THIS NOTICE AND DISCLOSURE STATEMENT(S) CONCERNING THE BELOW-LISTED PROVIDER(S) OUT-OF-NETWORK STATUS.

NAME OF OUT-OF-NETWORK PROVIDER(S):(MUST BE LEGIBLY PRINTED)
1. 
2. 
3. 
4. 
5. 
6. 

_____________ (Enrollee/Patient Initials/Date)

I have been provided the following:


_________ (Enrollee/Patient Initials/Date)

2. THE CIRCUMSTANCES UNDER WHICH I WOULD BE RESPONSIBLE FOR THOSE AMOUNTS DISCLOSED.

_________ (Enrollee/Patient Initials/Date)

A SEPARATE NOTICE AND DISCLOSURE STATEMENT FROM EACH OUT-OF-NETWORK PROVIDER.

(Enrollee/Patient Initials/Date)

3. I understand that the above-listed provider(s) are out-of-network and do/does not have a contract with my health benefit plan.

_________ (Enrollee/Patient Initials/Date)

4. I acknowledge that I have received the following:
   a. a COMPLETE list of all nonemergency health care services/procedures scheduled to be performed by each of the above-listed out-of-network provider.

_____ (Enrollee/Patient Initials/Date)
b. A written disclosure of the projected total amount for the non-emergency health care services to be provided by each of the above-listed out-of-network provider(s), including any charges for health care or medical services and supplies.

_______ (Enrollee/Patient Initials/Date)

c. A written statement containing the total amount to be billed amounts for each service provided by the out-of-network provider, less any insurance payments to the enrollee.

_______ (Enrollee/Patient Initials/Date)

5. I HEREBY ACKNOWLEDGE THAT I AM THE PATIENT/ENROLLEE. I HAVE BEEN PROVIDED THE ABOVE INFORMATION BY EACH OF THE ABOVE-LISTED OUT-OF-NETWORK PROVIDER(S) IN A SEPARATE STATEMENT ATTACHED HERETO.

_________ (Enrollee/Patient Initials/Date)

6. EACH STATEMENT ATTACHED HERETO WAS EXPLAINED TO ME, IN–PERSON, AT LEAST 7 DAYS BEFORE ANY OF THE DESCRIBED NONEMERGENCY HEALTH CARE SERVICES/PROCEDURES, MEDICAL CARE, OR SUPPLIES WERE RENDERED OR PROVIDED.

_________ (Enrollee/Patient Initials/Date)

7. I HEREBY: (Initial only one)

________ ACCEPT the nonemergency health care services from the out-of-network provider and agree to accept financial responsibility as presented in the attached Notice and Disclosure Statement.

________ DECLINE the nonemergency health care services from the out-of-network provider at the disclosed rate presented in the attached Notice and Disclosure Statement.

I HAVE NOT BEEN COERCED OR PLACED UNDER DURESS IN ACKNOWLEDGING AND SIGNING THE NOTICE AND DISCLOSURE STATEMENT.

_________________________________________  ____________
Patient Signature                                      Date

______________________________________________
Patient Name (Printed)