AdvocateAuroraHealth®

MEDICARE OUTPATIENT COINSURANCE NOTICE
(Off Campus Hospital Based Departments Only*)

To our Medicare patients:

Medicare regulations require us to provide you with a notice of your potential financial liability for the hospital services you will receive.

We are required to advise you that because the services are furnished by a department of

_____, you will incur a coinsurance liability to the hospital that may be
(Hospital Name)
different than the coinsurance liability you would incur if the services were furnished in an entity that is not hospital-based. At this time, we can provide you with the following information on the estimated amount of your coinsurance liability:

☐ Your coinsurance liability for hospital services is *estimated* to be $_____ based on our current information about scheduled services.

☐ At this time, because we do not know the exact type and extent of services that you may need, we are providing you with an estimate based on a typical visit. $_____

The actual amount of your coinsurance liability to the hospital may be different from any estimate that is provided above. Actual coinsurance liability will be based on the services that you receive and is also subject to final determination by the Medicare program.

If you are enrolled in a state medical assistance program (Medicaid) your coinsurance liability may be reduced or eliminated by law.

Your coinsurance liability for hospital services is separate from the Medicare coinsurance liability that you may owe for any physician or professional services provided to you in conjunction with hospital services.

I have read the foregoing and understand that I will incur a liability to the hospital for Medicare coinsurance as permitted by law.

_____	_____	_____
Date	Time	Signature of patient or authorized representative

***NOTE FOR CAREGIVERS:** This form is only to be used at off campus hospital-based clinics.

INSTRUCTIONS: Return completed form to Registration for scanning to HAR.