Advocate Health Care | Aurora Health Care

Now part of ADVOCATEHEALTH

Patient Label Box

Financial Responsibility Agreement

(not for use with Medicare Part A or B)

Notice Date: _____

Service(s): _____

_____

_____

I understand the non-emergency service(s) identified above may not be covered (paid) by my health plan for one or more of the reason(s) listed below:

- Advocate Aurora Health, Inc. ("AAH") is out of network for my insurance plan, does not participate in the plan, or is not part of the network choice that pays the highest benefits for me. My service(s) may be paid at a reduced rate or, may be denied as non-covered, or I may need to submit a claim to my plan. Using AAH for my services means I will owe a larger patient portion, and I may owe the full charges.
- My insurance authorization or HMO referral has not been approved.
- I have exceeded my allowable frequency of services/visits based on information provided to me by my insurance provider.
- My health plan has made the determination that my planned service(s) will not be covered.
- My insurance plan deems the medically necessary services as investigational/experimental/unproven and I understand they will not be covered.
- Other (specify) _____

I have been informed of my estimated costs. I understand that by proceeding with these services, I am accepting full financial responsibility. This waiver will override the patient responsibility statement on the explanation of benefits from my insurance plan.

_____ _____ _____

Date Time Parent/Guarantor Signature

Interpreter Assistance: If an interpreter assisted, please complete the following: Language: _____

Date: _____ Time: _____ Interpreter Name: _____ ID #:_____

Services may not be scheduled until such time as this signed form is received by AAH and the estimated patient portion paid. Our Financial Advocates can be reached at phone number 800-326-2250 WI or 847-795-2300 IL.