Patient Billing Acknowledgement Form
Non-Covered Services**

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as supplies, vitamins, or durable medical equipment.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.
** **Not for use in New Jersey**

PROVIDER

Services to be provided:

Supply _____ DME _____

Modalities/Procedures _____ Other _____

Time frame from _____ through _____

Schedule/details _____

Provider Signature: _____

PATIENT

I _____, acknowledge that I have been told
Patient Name – Printed or Typed
in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature Date

_____ _____

Patient Billing Acknowledgement Form
Maintenance/Elective Care**

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

** **Not for use in New Jersey**

PROVIDER

Services to be provided are listed below:

Chiropractic Manipulative Therapy _____ In-Home Care _____

Modalities/Procedures _____ Other _____

Time frame from _____ through _____

Schedule/details _____

Provider Signature: _____

PATIENT

I _____, acknowledge that I have been told
Patient Name – Printed or Typed
in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature Date

_____ _____

Insurance Benefit Plans

English

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan's phone number at 1-800-428-6337
Someone who speaks (your language) can help you. If you need more help, call the CA Dept. of Insurance at 1-800-927-4357

Español

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o plan de salud. Para obtener la ayuda de un intérprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su plan de salud al 1-800-428-6337
Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357
(Spanish)

中文

請注意：您可以免費取得口譯員服務，與您的醫師或醫療保險計畫聯絡。
欲取得口譯員服務或詢問中文的書面資料，請先致電您的保健計畫，電話號碼
1-800-428-6337
我們有會説中文的人為您服務。若您需要其他協助，請致電 1-800-927-4357
與加州保險局聯絡。
(Chinese)

HMO Benefit Plans

English

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-800-428-6337

Español

IMPORTANTE: ¿Puede leer esta carta? Si no, alguien le puede ayudar a leerla. También puede recibir esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1-800-428-6337
(Spanish)

中文

請注意：您是否能閱讀此信件？若您無法閱讀此信，我們將為您提供專員服務。
您也可以取得本信件的中文書面翻譯。欲洽詢免費服務，請立即致電
1-800-428-6337
(Chinese)