St Luke's PHYSICIAN GROUP

Financial Liability Acknowledgement Form

Member's Name: _____ Date: _____

Insurance Company: _____ Provider Name: _____

Member ID #: _____ Group/Provider ID#: _____

We expect that the insurance company listed above will not pay for the services described below:

_____

_____

You may be responsible for the above listed service(s) due to the following reason(s):
(Check all that apply)

- ☐ Insurance does not pay for the services rendered; for example non-covered services, such as preventative care, physicals or flu shots. Please see your Member Handbook/Evidence of Coverage for a complete listing of the non-covered services.
- ☐ Services are not covered without a Referral from your Primary Care / OB-GYN / Specialist Physician.
- ☐ Services are not covered without prior Authorization/Pre-Certification by your Insurance Plan.
- ☐ Service has been determined to be not medically necessary by your Insurance Plan.
- ☐ Insurance does not pay for this service because it is considered investigational.
- ☐ Insurance does not pay for this type of service unless it was due to an emergency.
- ☐ Our office does not contract with your insurance company and you are considered Out-Of-Network.
- ☐ Other: _____

_____

The provider identified above has notified me that the requested service(s) is non-covered for the reason(s) stated above. I understand that I am fully responsible for payment of the services listed above. Payment is required at time of service unless prior arrangements have been made and agreed upon by the Manager and/or Central Business Office.

_____ _____
(Member Signature) Date:

_____ _____
(Witness Name) (Witness Signature)

In the event that the patient is a minor, the undersigned parent/guardian of that minor, agrees to be financially responsible for the services described above.

_____ _____
(Parent/Guardian Signature) Date:

_____ _____
(Witness Name) (Witness Signature)