UCSF Medical Center

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

PATIENT AGREEMENT OF FINANCIAL RESPONSIBILITY* (DOES NOT APPLY TO EMERGENCY SERVICES)

I, _____ have been notified that my health insurance plan may deny payment and/or full
Patient or patients legal representative name - please print

coverage for the following non-emergent service(s): _____
Specific and complete description of service(s)

to be rendered by doctor: _____ on ____/____/____
Date of service

Estimated Charges: $ _____

The "estimated charge" is only an estimate. The actual charges(s) could exceed this amount. You will be required to make full payment of this estimate in advance for any noncovered or nonauthorized services or share-of-cost liability, as payment toward the total charges. Other associated charges could include additional services such as anesthesia, laboratory, x-rays, physician charges, or hospital charges that are **not** included in this estimate.

Patient Liability Reason: Patient and/or guarantor to initial next to liability reason.

_____ Initials

1. No insurance coverage, Managed Care Plans (PPO, HMO, EPO) I understand that these services, which are being provided at my own request:

- ☐ are not covered under my benefit package
- ☐ I request that my insurance not be billed nor notified of this service(s)
- ☐ are conditionally covered under my benefit package
- ☐ are not authorized by my insurance carrier, Primary Care Physician/Primary Medical Group
  - ☐ post stabilization (transfer refusal)

_____ Initials

2. Medi-Cal and/or Medi-Cal Managed Care Plan I understand that Medi-Cal has determined these services, that are being provided at my own request:

- ☐ are not-covered benefits
- ☐ are not authorized by Medi-Cal and/or my Primary Care Physician/Primary Medical Group
- ☐ is designated as a "Share-of-Cost" liability

_____ Initials

3. Medicare

Medicare will only pay for those services that are covered by the program and that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. UCSF Medical Center believes that, in my case, Medicare is likely to deny payment for the scheduled service for the reason below (check one below).

- ☐ Routine physical exams and/or screening procedures
- ☐ Outpatient medications
- ☐ Services related to noncovered services
- ☐ Services are conditionally covered
- ☐ Services not medically reasonable or necessary
- ☐ Other _____
- ☐ Experimental/investigative services
- ☐ Cosmetic surgery
- ☐ Personal comfort items
- ☐ Supportive devices for the feet (non-medically necessary)
- ☐ ABN signed

_____ Initials

4. Financial assistance information provided

_____ Initials

5. Other Reason _____
Describe in detail

_____ Initials

Financial Agreement: I have been notified that my health insurance plan may deny payment or full coverage for the service(s) and reason described above. UCSF Medical Center requires that I make payment in advance for "share-of-cost" liability, noncovered, or nonauthorized service(s). By signing this form, I understand and agree to be personally and fully responsible for the payment of this service(s).

Signature of patient or patient representative	(if other than patient, include relationship)	____/____/____ Date
Signature of guarantor if other than patient	Print Name	____/____/____ Date
Signature of UCSF Medical Center Representative	Print Name and Department	____/____/____ Date

**This form is utilized after the patient has been provided with the notification of financial assistance and charity care program.*

876-070 (Rev. 03/09) WorkflowOne SIGNED COPY TO: WHITE - PATIENT FINANCIAL SERVICES GREEN - DEPARTMENT OF PROF. SERVICE OFFICE CANARY - PATIENT