This page must be completed for patients with out-of-network insurance and must be provided at time of first contact with the patient regarding the health care service.

Patient's Name: ____

Patient's Date of Birth: _________________________

Michigan Surprise Medical Billing Disclosure Form

Your health benefit plan may or may not provide coverage for all of the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan.

The nonparticipating provider must provide a good-faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have a right to request that the health care services be performed by a provider that participates with your health benefit plan, and may contact your carrier to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform health care services that you need.

I have received, read, and understand this disclosure.

____ __________________________

(Patient or patient's representative's signature) (Date)

____

(Type or print name of patient or patient's representative)

After patient's signature is obtained, this form must be documented in medical record under "Insurance Documents"

March 20, 2023