Billing Members for Services
Patient Financial Responsibility Acknowledgement Procedure and Form

Members may not be charged for services beyond the applicable copayment, deductible or coinsurance applied by their benefit. However, a member may be charged for services that have been denied authorization by Magellan if the member agrees, in writing, to be financially responsible for such services. The member's written agreement must be obtained after the services have been denied or non-authorized, but before they have been provided. General financial responsibility acknowledgments signed upon admission are not sufficient. A sample form is included in this Appendix K. To ensure that the member has been properly informed of his or her rights, the written agreement must contain the following elements:

1. The dates of service denied by the plan or the last day authorized by the plan
2. The reason for the denial or for the non-authorization by the plan
3. The alternative covered treatment recommended by the plan
4. A description of the self-pay services
5. The dates of service of the self-pay services*
6. The estimated cost of the self-pay services
7. Acknowledgment that the member has been informed of his/her rights to appeal, including without limitation, the right to file an independent medical review (IMR) directly with the California Department of Managed Health Care (DMHC)
8. Signature and date of the patient or patient's legal representative**
9. Signature and date of a witness

*Dates of service for self-pay services cannot pre-date the denial or non-authorization. Members may not be billed for non-covered services if consent is not obtained prior to the start of non-covered services.

**Signature date must be on or after the date of the denial or last covered day and prior to the start of non-covered services.

Waivers deemed to be invalid due to missing any of the elements above may result in providers being required to refund all inappropriately obtained funds to members. Please note that this waiver is required even if you elect to appeal the denial or non-authorization. Updates to the status of the denial or non-authorization require an updated waiver. If the denial or non-authorization is overturned on appeal, the waiver is rendered invalid and the member may not be billed other than for copayment/coinsurance/deductible. **The California Department of Managed Health Care (DMHC) ultimately determines whether or not a waiver is valid.**

As a reminder, the Member Hold Harmless Commitment section of the agreement states:

In the event a Member requires services which are beyond the scope or duration of Medically Necessary Covered Services under this Agreement, Facility shall verify with Payor that the Payor has no independent obligation to provide those non-Covered Services and if that verification is obtained from Payor, Facility may bill the Member for those non-Covered Services; provided, however, that prior to delivering such services, Facility informs the Member that such services are non-Covered Services and Member elects in writing to receive those non-Covered Services prior to having such services delivered. Any rates charged

by Facility to a Member for non-Covered Services in accordance with the provisions of this section, shall be the rates negotiated by Facility and Plan for such services set forth in the Exhibits to this Agreement.

The above statement should not be construed by the facility to mean that the facility may provide a higher level of care than that authorized by the plan. Nor may the facility bill the member for the difference between what is authorized and what is provided. This practice is prohibited under the contract and may be considered as balance billing by the California Department of Managed Health Care.

Patient Financial Responsibility Acknowledgement

******SAMPLE FORM******

Health Plan: _____

Provider Name: _____

Patient Name: _____ Patient DOB:_____

Subscriber: _____ID#: _____

The undersigned patient acknowledges the following:

A. My health benefits plan has denied coverage for the following services: ___(Identify type of service/ level of care, CPT codes used for billing purposes)_____
   The denial is effective: __(Insert date of first non-covered day/visit)_____
B. An alternative treatment option offered by the health benefits plan is:
   _____
C. I have been informed of my rights to appeal this determination through the plan's appeal/grievance process. ☐Yes ☐No Comment: _____
D. I have been informed that I may go directly to the Department of Managed Health Care to appeal this decision if expedited (urgent). ☐Yes ☐No Comment: _____
E. I have asked and given permission for the provider/facility to appeal this decision on my behalf. ☐Yes ☐No Comment: _____
F. I understand that if I receive treatment for the denied service I will be completely financially responsible for all costs unless the denial is overturned on appeal. ☐Yes ☐No
G. It is my understanding that the cost for the services for which I am responsible are: _____
   (List all CPT codes and the amount that will be charged to the member; include effective date)____
   _____

I have been informed of all the information outlined above and agree to pay to the provider the cost for the services to be rendered at the rate listed above.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Signature of Provider or Provider's Witness Date

This is an example of a Financial Waiver Form that contains all the required information and permissions to consider a waiver valid. It is provided as a courtesy by Human Affairs International of CA, a subsidiary of Magellan Health, Inc.