Laboratory Services

Huntsville Hospital
101 Sivley Road, Huntsville, Alabama 35801
Notice of Patient Financial Responsibility

Patient name: _____

Date of service: _____

Your health insurance plan requires that your physician obtain a pre-certification number prior to some services being provided.

Your physician has requested that you be provided the services listed below. In accordance with the guidelines of your insurance policy, the requested service requires that your physician obtain a precertification authorization. Huntsville Hospital has not received this pre-certification number from your physician insurance carrier.

The fact that your insurance company or your physician has not provided a pre-certification number for a particular item or service does not mean that the item or service is not medically necessary or that you should not receive it. The following services were requested on your behalf by your physician. We are providing you with an estimated cost of those services.

Procedure: _____

Cost: _____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these item(s) or service(s), knowing that you may have to pay for them yourself out of pocket

PLEASE CHOOSE ONE OPTION, CHECK ONE BOX, SIGN AND DATE YOUR CHOICE.
I = Patient, You = Huntsville Hospital

___ **Option 1:**
I WANT THE SERVICES/ITEMS LISTED ABOVE. You may be asked to be paid now, BUT I ALSO WANT MY INSURANCE BILLED FOR AN OFFICIAL DECISION ON PAYMENT, which is sent to me on a Medicare Summary Notice (MSN). (MSN applies to Medicare payers only). I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN (Medicare payers only). If my insurance does pay, you will refund any payments I made to you, less co-pays and deductibles.

___ **Option 2:**
I WANT THE SERVICES/ITEMS LISTED ABOVE, BUT DO NOT BILL MY INSURANCE. You may ask to be paid now as I am responsible for payment. I cannot appeal if my insurance is not billed.

___ **Option 3:**
I DON'T WANT THE SERVICES/ITEMS LISTED ABOVE. I understand with this choice I am not responsible for payment, and I cannot appeal to see if my insurance would pay.

Patient signature: _____

Date: _____