

## Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and possibly pay more for out-of-network care.

**IMPORTANT:** You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

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You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

### **Getting care from this provider or facility could cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

**You shouldn't sign this form if you didn't have a choice of providers** when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

## Estimate of what you could pay

Patient name: \_\_\_\_\_

Out-of-network provider(s) or facility name: \_\_\_\_\_

<b>Total cost estimate of what you may be asked to pay:</b>	
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▶ **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.

▶ **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

▶ **Questions about this notice and estimate?**

*Same Day Surgery cases* contact: Jackie S at (952)898-8801.

*Orthognathic Surgery cases* contact: Becki D at (952)841-9653.

▶ **Questions about your rights?** Contact Health and Human Services

▶ **Prior authorization or other care management limitations**

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

**More information about your rights and protections**

Visit [www.hhs.gov](http://www.hhs.gov) for more information about your rights under federal law.



# More details about your estimate

Patient name: \_\_\_\_\_

Out-of-network provider(s) or facility name: \_\_\_\_\_

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

**Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.**

Date of service	Service code	Description	Estimated amount to be billed
<b>Total estimate of what you may owe:</b>			