Independence

4/2020

Member consent for financial responsibility for unreferred/non-covered services

Member information

Member name _____

Member's ID # _____

Provider information

Provider name _____

Provider's ID # _____

Specialty or department _____

Type of service _____

Member must complete this section

As a member of: Keystone Health Plan East (HMO) Personal Choice® (PPO)
(Circle one)

I understand that…
(Check the appropriate box):

- ❑ A referral from my Primary Care Physician is required for any and all non-Emergency outpatient hospital/specialist services. I acknowledge that I do not have a referral with me at this time, but I choose to receive the services without the required referral. I understand that without the appropriate referral, I will be held responsible for any payments incurred for these services. (HMO)
- ❑ I understand that this is a noncovered service for which my insurance carrier will not make payment and I agree to be financially liable for any payments incurred for these services. I understand that I have the right to appeal this determination. (ANY)
- ❑ I understand that certain services will only be covered by my insurance carrier when performed by designated providers or in certain settings (e.g., capitated radiology or lab services, and DME services). I understand and agree that I will be financially responsible for certain services that I choose to receive from the provider noted above rather than the designated network provider or in the appropriate setting. The provider has specifically explained to me the services for which I will be financially responsible. (ANY)
- ❑ I understand that I will be responsible for all fees incurred if this visit or any other service precedes the effective date that has been assigned to my enrollment or my dependent's enrollment. (ANY)

_____ _____
Member's signature *Employer name (if applicable)*

_____ _____
Date *Employer address (if applicable)*

_____ _____
Witness / office staff *City* *State* *ZIP*