McLaren Business Products

McLaren Print System Order

Order No: 63053 Reprint Previous Order No: 5304
Order Date: 2021-06-16
User: Chelsey Johnson
Phone: 517-715-7608

Ship Location: ATTN: Chelsey Johnson
2073 Aurelius Road
Holt, MI 48842
Forms
Quantity: 2500
Paragon Dept No: 67350
Dept Name: MGL- Holt Family Practice
Company Number: 810

Order Total Price: 75.50

Item Number: MM-105
Item Description: Notice of Financial Responsibility (Medicaid)
Revision Date: 8/2019
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Medical Group

NOTICE OF FINANCIAL RESPONSIBILITY

Patient Name: _____ **Date of Birth:** _____

Date of Service: _____ **Insurance Carrier:** _____

Provider Name: _____

You are seeking treatment from this office and services may not be covered by your insurance for one or more of the following reasons. If you choose to receive services from this office, you will be expected to pay any amount not covered by your insurance.

____ You are not assigned to one of our Primary Care providers

____ This office does not participate with your insurance carrier

____ The services you are seeking may not be a covered benefit under your insurance

____ You do not have a valid authorization on file for the services you are seeking

____ Other: _____

Any questions regarding your insurance coverage should be directed to your insurance carrier

Patient Agreement:

I have been notified that treatment at this office may not be covered by my insurance for the reason(s) stated above. I understand the explanation given. I agree to be personally and fully responsible for any amount not covered by my insurance.

_____ _____

Patient or Guardian Signature Date

_____

Witness

MM-105 Rev. (8/19)