McLaren Medical Group

HMO PATIENT
FINANCIAL RESPONSIBILITY

Your health insurance _____ requires a referral from your primary care physician (PCP) for each visit/procedure with a specialist.

I have requested a referral from my PCP. I am aware that failure to obtain proper authorization may result in rejection of this claim and the charges would then become my responsibility.

_____ _____/_____/_____

Signature of Patient/Parent/Legal Guardian **Date**

HMO PATIENT
FINANCIAL RESPONSIBILITY

MM-51 (10/10)

Original-Med Rec. Copy-Patient

Patient Name:

Date of Birth: