Surprise Billing Protection
Notice, Consent and Cost Estimate

McLaren HEALTH CARE

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 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.

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: _____

_____

Total cost estimate of what you may be asked to pay (from page 4):	

- **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?** Call the McLaren Central Business Services Office at (800) 591-8707 for questions relating to this estimate.
- **Questions about your rights?** Contact the Centers for Medicare and Medicaid Services at 1-800-985-3059.

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.

This section applies only if you will be receiving post-stabilization services by a non-participating provider within this participating McLaren emergency facility:

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan at this McLaren facility:

_____

_____

_____

_____

More information about your rights and protections

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from the following doctor(s), provider(s) and facility/facililties (select all that apply and add more names if needed):

☐ _____

☐ _____

☐ _____

☐ _____

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on this date _____ explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ or _____

Patient's signature | Guardian/authorized representative's signature

_____ _____

Print name of patient | Print name of guardian/authorized representative

_____ _____

Date and time of signature | Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

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
		owe (add the total to page 2):	