



## 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 (from page 4):</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?** 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](http://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/facilities (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.
- For services in Michigan, this estimate does not take into account unforeseen circumstances which may affect the cost of the services provided.

**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.

\_\_\_\_\_  
Patient's signature

or

\_\_\_\_\_  
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.**