Hackensack Meridian *Health*
Bayshore Medical Center

Bayshore Medical Center
727 N Beers St, Holmdel, NJ 07733

Billing & Insurance
732-530-2250

ACKNOWLEDGEMENT OF REQUEST FOR OUT-OF-NETWORK PROVIDER SERVICES

Patient Name: _____ HAR #: _____

Reg. Date/Time: _____ MR #: _____

I, _____ have been informed that the hospital named above is **outofnetwork** with my health insurance plan and further:

✓ My potential financial responsibility may exceed my copayment, deductible or coinsurance with my health insurance plan.

✓ I may be responsible for any excess amount above the allowed amount the health insurance plan pays or reimburses the provider for healthcare services I received; and

✓ I should contact my health insurance plan to identify the specific potential costs for which I am/may be responsible.

I acknowledge that I am **knowingly and voluntarily** accepting responsibility for any out-of-network financial responsibility associated with healthcare services that I receive.

_____ _____
Patient Name (Print) Patient Signature

Date signed: _____

_____ _____
Witness's Name (Print) Witness's Signature

Date signed: _____