

Ocean Medical Center 425 Jack Martin Blvd, Brick, NJ 08724 Billing & Insurance 732-836-4499

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:

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

 \checkmark 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

 \checkmark 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: _____

Effective: 09/01/2018