

Hackensack University Medical Center 30 Prospect Ave., Hackensack, NJ 07601

Billing & Insurance 551-996-3355

Effective: 09/01/2018

ACKNOWLEDGEMENT OF REQUEST FOR OUT-OF-NETWORK PROVIDER SERVICES

Patient Name: _____ HAR #: _____

Reg. Date/Time:	MR #:
I,named above is outofnetwork with my h	
✓ 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	
$\checkmark~\rm I$ 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:	-