PLEASE SIGN, DATE AND RETURN

OPTUM

9655 Florida Mining Blvd West Ste 411
Jacksonville, FL 32257-2041
Phone:(904) 652-1990

Date: **02/22/2021**
Patient Name: **TEST TEST**
MRN: **573595**

NOTICE OF FINANCIAL RESPONSIBILITY

☐ Annual Renewal ☐ Plan Change ☑ SOC ☐ Therapy/Drug Change

Payors: 26 Aetna MMA

I understand that my primary insurance has agreed to pay **80** % of allowable charges and that my secondary insurance (If applicable) will be billed for **0** %.

I understand that I am responsible for **20** % of allowable charges after my deductible has been met.

My **approximate** out of pocket cost will be: Deductible $ **2500** /Out of Pocket $ **5000** /Copay $ **0.0**

Other: **Patient has coverage at 80% until the max out of pocket has been satisfied for the calendar year through Aetna $2500deductible/$2000deductible met. $5000out-of-pocket/$2000out-of-pocket met. Patient has an expected out of pocket expense approximately $15.31/day. ***This quote of benefits is valid through 12/31/2017*****

Your deductible and maximum out of pocket costs will apply with the annual renewal of your policy.

While I understand that Optum Infusion Services has attempted to verify benefit coverage with a representative of a third party payer, such verification of benefits is not a guarantee of payment. Charges may be subject to medical review and authorization by my insurance company during my therapy and my insurance company may, or may not, approve the services as ordered by my physician.

** Please note you have the right to appeal such decisions; however, payment arrangements for therapy provided, must be made in these cases.**

I acknowledge that I am financially responsible for, and I agree to pay Optum Infusion Services, in a timely manner, all charges for products and services provided. If I, TEST TEST, fail to make timely payments, I will be responsible for any expenses incurred by Optum Infusion Services, in the collection of such charges, including attorney's fees. This obligation is binding upon my successors, my estate, and my executors and administrators.

Signatures: This form must be signed by the patient or patient's legal representative

Real Signs _____ _____ 9/20/2024

Patient/Legal Guardian/Patient's Legal Representative | Relationship | Date