Member (Patient) Payment Responsibility Agreement

Optum contracted clinicians/facilities ("Providers") are prohibited from charging Optum Members for any service or supply that is determined by Optum not to be Medically Necessary, ***unless*** the Member (or his/her authorized representative) specifically agrees to be responsible for payment by execution of a completed Payment Responsibility Agreement.

This Payment Responsibility Agreement MUST be executed in advance of the provision of the service or supply for which the Member is to be financially responsible for payment to the Provider and the Member must have been informed of, and specifically acknowledge, that the Member is aware that Optum has determined that the service or supply was not Medically Necessary. In order to be considered effective and valid, this Payment Responsibility Agreement must be executed prior to the delivery of any such service or supply and the Member must have received notice of the denial (including information regarding their appeal rights).

This Payment Responsibility Agreement shall be used by the Provider in such instances and must be separate from any patient payment responsibility information that is signed by the Member at the onset of treatment or that is part of the provider or facility admission form(s).

Member (Patient) Name: _____ DOB: _____

Subscriber ID: _____ Group Number: _____

Provider: _____

Provider NPI/Tax ID: _____

Provider Phone: _____

Member:

By signing below, I agree to pay the Provider for those services or supplies that my health plan or its administrator determined were not Medically Necessary.

I understand, pursuant to the Provider's Agreement with Optum, that a Provider may not charge me for a service or supply determined not to be Medically Necessary by Optum ***unless*** I have specifically agreed in writing, prior to delivery of such services or supplies, to be personally responsible for and pay for such services and supplies. Prior to signing this Patient Responsibility Agreement, I understand that Optum determined that the services and supplies listed below were not Medically Necessary and thus not covered by my health plan or insurance. I also understand that the Provider and/or I may appeal any determination that a service or supply is not Medically Necessary. I further understand nothing in this Agreement may be construed to limit any other rights I have under state or federal law. I also understand that receipt of such services or supplies without my signature below cannot be charged to me personally.

I understand that, for the specified services and supplies listed below received after the date of signature below, I will be personally financially responsible for payment for such services and supplies directly to the Provider and that they are not covered by my health plan or insurance, even though the cost for these services and supplies may not be shown on my Explanation of Benefits ("EOB") as my financial responsibility. I also understand that an appeal of a non-Medical Necessity determination does not assure that I will not be personally financially responsible for services or supplies related to the appeal.

Description of Services/and/or Supplies	Date of Proposed Service

_____ _____

Signature of Member or Authorized Representative Date