

## Patient Financial Responsibility Letter

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Insurance: Primary \_\_\_\_\_ Secondary \_\_\_\_\_ Tertiary \_\_\_\_\_

### Services Provided

Pharmacy      Nursing      Equipment      Other

Benefits verified with your insurance company for our services are as follows: Annual deductible \$ \_\_\_\_\_

Coverage is \_\_\_\_\_ % of charges

Annual maximum out of pocket expense \$ \_\_\_\_\_

Pharmacy co-pay amount \$ \_\_\_\_\_

Was a pump provided for medication administration      Yes      No

If yes:

Specific Pump: \_\_\_\_\_

Cost for Replacement if not returned: \_\_\_\_\_

Your insurance company does not cover these services. You are responsible for all charges for services given. Your estimated cost for the services provided is as follows: \$ \_\_\_\_\_

Your insurance coverage for our services could not be verified prior to services being rendered. You have given us permission to provide services with the understanding that you may be responsible for 100% of the charges. Your estimated total cost may be \$ \_\_\_\_\_.

• We will contact you as soon as possible once we can confirm your benefits.

Additional comments: \_\_\_\_\_

**Note:** The amounts indicated above were quoted to us by your insurance company at the time of insurance verification. We cannot guarantee that the amounts are final and may not change since they were based on information given at that time. Any changes made to your initial medication order prescribed by your physician may also affect the amount due. If such a change occurs, you will be notified. You will receive services and we will provide services with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for the services provided. If your benefits change or the insurance(s) listed above change, it is your responsibility to notify us as soon as possible. If you do not notify us in time to meet your insurance claim filing requirements, you will be financially responsible for the entire amount due. If your pharmacy coverage is through a Medicare D plan, your co-pay amount may vary with each shipment. A full explanation of Medicare D drug coverage will be provided to you prior to starting services.

For questions, please contact our Billing Department at (877) 567-8087.