SAMPLE

FORMS
Minor Procedure Notification
at Time of Service

Explanation of billing when performing a minor surgical procedure in the office, e.g. fiberoptic flexible laryngoscopy, nasal endoscopy.

This letter could be given to patients to explain that the AMA CPT coding rules requires the physician to report a CPT code that is defined by the payor and the AMA as a “surgical” procedure.

Date: _____________
Dear. _____________:

Your insurance company requires that we bill our services to you using a coding system known as CPT (Current Procedural Terminology). The codes used to describe the services we did for you are found in the “surgery” section of the CPT codebook. This does not mean we are implying that you had an operation. This is merely the way the CPT book is organized for ease of use by both the insurance companies and physicians.

According to CPT guidelines, the procedure performed in the office today ____________________________ which shows on your bill as CPT code________ may be shown on your Explanation of Benefit form from your Insurance company as a surgical procedure. As such, your insurance company may apply a surgical co-insurance responsibility or deductible.

We are providing this letter to inform you of what you may see on your statement from the insurance company. Please know that we have correctly performed and documented the services as required by the CPT coding guidelines.

If you have any questions, please do not hesitate to contact ________________ in the billing office at __________________________

Sincerely,

List MD Name Here
# Surgical Cost Analysis Form

**Patient’s Name**

**Today’s Date**

**Proposed Surgery Date**

<table>
<thead>
<tr>
<th>Procedure Code(s)</th>
<th>Diagnosis Code(s)</th>
<th>Fee(s)</th>
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**Financial Responsibilities:**

- **Our Charges:** $__________________
- **Plan Allowable:** $__________________
- **Non-Covered Services:** $__________________
- **Deductible:** $__________________
- **Coincurrence:** $__________________
- **Your Total Responsibility:** $__________________
- **Total Deposit Due (50% of Total Responsibility):** $__________________

The deposit is due ten days prior to surgery. We will accept a personal check, cashier’s check, VISA/MasterCard, or cash. The balance of your financial responsibility is due at least two days prior to surgery unless other arrangements are made.

Our fee includes all postoperative visits for ______________ after the date of surgery.

You will receive a separate bill from the anesthesiologist.

Lab tests are extra and are billed by the physicians providing these services.

Our fee quotations are valid for one year.

If you have any questions, please call me. I’m your Surgery Coordinator:

<table>
<thead>
<tr>
<th>Surgery Coordinator Signature</th>
<th>Phone</th>
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<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date</th>
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</table>
Pre-Authorized Use of Credit Card

I authorize __________________________ (name of healthcare provider) to keep my signature on file and to charge my Visa / Mastercard for:

☐ Balance of charges not paid by insurance within 90 days and not to exceed $________________ for:
  ☐ this visit only.
  ☐ all visits this year.

☐ Recurring charges (on-going treatments or payment plan) of $__________
  every _______________ from ___________ to ___________.
  (frequency)                   (date)                           (date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

________________________________________
Patient Name

________________________________________
Cardholder Name

________________________________________
Cardholder Address

________________________________________
City                      State          Zip

________________________________________
Credit Card Account Number   Expiration Date

________________________________________
Cardholder Signature         Date
Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn’t pay for D. ____________ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. ____________ below.

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay:</th>
<th>F. Estimated Cost</th>
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WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. ____________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D. ____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D. ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don’t want the D. ____________ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature: J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.
I am hereby requesting that the following services be provided to me by __________________________.(Provider Name)  

<table>
<thead>
<tr>
<th>Service(s) (List All)</th>
<th>Frequency Limitations</th>
<th>Proposed Date(s) of Service</th>
<th>Estimated Cost of Service(s)</th>
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In making this request, I acknowledge that these services are not a benefit of my health coverage under TRICARE and that I will not receive the benefit of the TRICARE Hold Harmless Policy (defined below), which otherwise might apply to me. In addition, I acknowledge that if I have obtained services more frequently than authorized by TRICARE policy, I may be responsible for that professional service.  

I also understand that if authorization for this care has been denied by TRICARE, or if reimbursement is denied upon submittal of a claim form, I may appeal the written notification of the denial issued by Health Net Federal Services, Inc./MHN Services.  

Unless the decision to deny is overturned as the result of an appeal or dispute, I agree that I will be personally responsible for the payment IN FULL of the billed charges for these services.  

Sponsor Name

Patient Name (Print)

Sponsor Social Security Number

Signature of Patient

Sponsor Address

Date

**TRICARE Hold Harmless Policy:** A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) unless the beneficiary has been properly informed that the services are excluded or excludable and has agreed in advance in writing to pay for the services.

**Privacy Act Statement:**

In view of the fact that personal information is being requested from you, notice is hereby given as required by the Privacy Act of 1974. The information is requested and maintained under the authority of Chapter 55, Title 10, United States Code, Section 5101, Title 44, United States Code, and 41 Code of Federal Regulations 104-1100 et seq. The information is requested to establish or update information to control or process claims for payment. Routinely, the information will be used to determine eligibility for TRICARE benefits, review and approve medical care as TRICARE benefits, and to determine reasonable charges/costs of care to be cost-shared under TRICARE. Disclosure of the information is voluntary; however, failure to provide the information may result in denial of benefits.
<table>
<thead>
<tr>
<th>Patient</th>
<th>Health Insurance Number</th>
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<tbody>
<tr>
<td>Service Description</td>
<td>CPT</td>
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<tr>
<td>______________________</td>
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I have been notified by my physician that he or she believes that the above service(s) may be denied for payment as a noncovered service by my insurance company. I have requested these services be performed. I agree to be personally and fully responsible for payment.

__________________________________________  ___________
Signed (Beneficiary Signature)                  Date
Financial Responsibility for Payment Form

I, the undersigned, agree that I am financially responsible for all professional charges incurred for ________________ with ________________.

“Myself” or “Patient Name”                                              Name of physician

I understand that she/he is not a provider for my health insurance plan and I have voluntarily elected to seek treatment from an “out of network” provider of my plan. I accept full responsibility for the charges incurred and will comply with demands for payment.

_________________________________________  ____________________________
Date                                              Signature of Responsible Party

_________________________________________
Printed Name of Responsible Party