PLEASE TAKE NOTICE OF THE FOLLOWING REGARDING A REFERRAL AND OUR LEGAL REQUIREMENTS TO INFORM YOU ABOUT HEALTH BENEFIT PLAN PARTICIPATION:

Our facility has referred you to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. This referral is for services relating to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The provider that we have referred you to is/is not part of or represented by the same organization that our facility is part of or represented by. (circle by facility rep and places their initials) [\_\_\_]

Our facility is/is not directly scheduling, ordering, or otherwise arranging for these services to be provided to you. (circle by facility rep and places their initials) [\_\_\_]

If we are directly scheduling, ordering or otherwise arranging for these services, please take notice that we have verified/not been able to verify that the referred provider participates/does not participate in your health benefit plan. [circle by facility rep in two portions of the sentence and places their initials) [\_\_\_]

If you need to directly schedule, order or otherwise arrange for these services, please take notice of the following:

This provider may not participate in your health benefit plan and there may be applicable out-of-network rates.

You have the opportunity to verify whether the referred provider participates in your plan prior to agreeing to use the provider’s services.

Below is sufficient information about the referred provider so that you may obtain additional information about whether the referred provider participates in your plan and any applicable out-of-pocket costs should you use the referred provider’s services

Contact Name
Address
Phone Number
Email Address:
Website Address:

**I acknowledge receipt of this notice.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident, Resident’s Legal Representative or Responsible Party
Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Facility Representative
Date: