Agreement to Financial Liability

Provider Name: _____

Member Name: _____

Member ID #: _____

I have been informed by the above provider that Tufts Health Plan will likely not cover the service and/or item described below for any of the following reasons (check all that apply):

☐ The service and/or item may not be covered by Tufts Health Plan.

☐ I do not meet the guidelines for coverage for this service and/or item.
☐ I have met or exceeded the benefit limit offered by my plan.
☐ I have not complied with applicable authorization/referral requirements.

Service(s)/item(s) requested: **Quantity requested:**

Estimated cost for the service/item listed above (please specify if this is per unit/service):

$_____

Estimated total cost: $_____

If I choose to receive this service and/or item despite this knowledge and Tufts Health Plan doesn't pay for this service and/or item, I understand that I might have to pay the full cost of this noncovered service and/or item and that this cost will not apply to the benefits of my plan.

I have also been informed that, before obtaining this service and/or item I may contact Tufts Health Plan's Member Services Department for further information regarding coverage of the requested service and/or item.

WHAT YOU NEED TO DO NOW

- Read this notice, so you can make an informed decision about receiving this item and/or service.
- Ask any questions that you may have after you finish reading.

With the above understanding, I still want to receive this service and/or item. I may be asked to pay for this service and/or item now, but I understand that once paid I or my provider may then submit a claim to Tufts Health Plan to be considered for reimbursement. If this request is denied, I will be notified in writing and provided guidance on my appeal rights.

Additional Information

If you have questions, please refer to your Evidence of Coverage or Description of Benefits, or contact Tufts Health Plan's Member Services Department at the number listed on your ID card.

Hours of Operation: Monday–Thursday 8 a.m.–7 p.m., Friday 10 a.m.–5 p.m.

By signing below, I acknowledge that I have read and understand the terms of this agreement waiver, have asked any questions I may have, and agree to the terms stated herein:

Signature:	**Date:**

Provider Services