

# HMH - Bayshore Medical Center 727 N Beers Street, Holmdel, NJ 07733 - 732.530.2250

www.hackensackmeridianhealth.org

#### **FACILITY IN-NETWORK DISCLOSURE**

Patient Name:	_ Health Benefits Plan:
	r is in-network for the health benefits plan named above and your financial will be no greater than your in-network copayment, deductible, and/or
	care professional, such as your doctor, or the physician assistant or ordered the services, to determine if they are in- network or out-of-network
care in this facility. You can e physician, services may inclu information regarding the hea Bayshore Medical Center we	fessionals other than the one ordering the service may provide and bill for expect services to be provided by other consultants requested by your ude but not limited to anesthesia, lab, radiology, etc. You can access alth benefits plans that these health care professionals participate in on HMH ebsite at <a href="https://www.hackensackmeridianhealth.org">www.hackensackmeridianhealth.org</a> . If you do not have internet nation will be provided to you upon request by HMH-Bayshore Medical Center.
and/or coinsurance amount, from HMH-Bayshore Medical If the bill is from a health care	n-network providers for more than your in-network copayment, deductible, you should report this information to your insurance carrier and, if the bill is Center, to the Department of Health at (800) 792-9770.  The professional, you should report this information to the appropriate in the Division of Consumer Affairs, Department of Law and Public Safety at
The amount you owe an in-necoinsurance amount per you	etwork provider will not be more than any in-network copayment, deductible, r health benefits plan.
	of-network provider, you will be asked to sign an acknowledgement of ces, which may exceed your in-network copayment, deductible, and/or
	benefits plan for information regarding your copayment, deductible Contact information is typically found on the card provided to you by your
<ul> <li>HMH-Bayshore Medical Center Medical Center changes before</li> </ul>	staff will notify you in the event the in-network status of HMH-Bayshore pre services are provided.
I agree that I have read and under	stand this form and have been provided a copy of it
Dationt's Cianature	Date

Patient's Signature



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Patient Name: \_\_\_\_\_ Health Benefits Plan: \_\_\_\_\_

Patient's Signature	Date
this facility. You can expect for services may include but not li health benefits plans that these website at <a href="https://www.hackensackm">www.hackensackm</a> will be provided to you upon re-	ssionals other than the one ordering the service may provide and bill for care in services to be provided by: other consultants requested by your physician, mited to anesthesia, lab, radiology, etc. You can access information regarding to health care professionals participate in on HMH-Bayshore Medical Center eridianhealth.org. If you do not have internet access, a copy of this information equest by HMH-Bayshore Medical Center.
	enefits plan for information regarding your copayment, deductible and/or nformation is typically found on the card provided to you by your health benefit
	re professional ordering the services to be provided in HMH-Bayshore Medical e is in-network or out-of-network for your health benefits plan.
,	ce between what your health benefits plan pays HMH-Bayshore Medical shore Medical Center charge for the services provided.
<ul> <li>The total amount you owe may be required by your health benefit</li> </ul>	e more than the copayment, deductible, and/or coinsurance amount is plan.
HMH-Bayshore Medical Center i	s out-of-network for the health benefits plan named above.



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## SELF-FUNDED PLAN OUT-OF-NETWORK DISCLOSURE

Patient Name:	Health Benefits Plan:
• HMH-Bayshore M	edical Center is out-of-network for the self-funded plan named above.
<ul> <li>The total amount y by your self-fund</li> </ul>	you owe may be more than the copayment, deductible, and/or coinsurance amount required ded plan.
	ed the difference between what your self-funded plan pays HMH-Bayshore Medical Center IH-Bayshore Medical Center charge for the services provided.
	et your self-funded plan administrator for information regarding your copayment, deductible nce amount. Contact information is typically found on the card provided to you by your self
	et the health care professional ordering the services to determine if he or she is in-network or or your self-funded plan.
have opted into on an urgent bas services rendere	ct your self-funded plan administrator for information 'copayment regarding whether they in-network coverage for out-of-network services provided inadvertently or in an emergency or sis. Billing disputes with self-funded plans that have opted into in-network coverage for ed in an emergency or on an urgent basis may be resolved through arbitration. Contact pically found on the card provided to you by your self-funded plan.
You can expect include but not li benefits plans the www.hackensacself-funded plan	ealth care professionals other than the one ordering the service may provide and bill for care. for services to be provided by: other consultants requested by your physician, services may imited to anesthesia, lab, radiology, etc. You can access information regarding the health hat these health care professionals participate in on HMH-Bayshore Medical Center website at the tekmeridianhealth.org. Services may be provided on an out-of-network basis in regard to your not have internet access, a copy of this information shall be provided to you upon H-Bayshore Medical Center.
I agree that I have read a	and understand this form and have been provided a copy of it.
Patient Signature	Date



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## SELF-FUNDED PLAN IN-NETWORK DISCLOSURE

Patient Name:	Health Benefits Plan:
	Il Center is in-network for the self-funded plan named above and your financial responsibility to this ater than your in-network copayment, deductible, and/or coinsurance amount.
	e health care professional, such as your doctor, or the physician assistant or advance practice the services, to determine if they are in-network or out-of-network for your self-funded plan.
expect for services to to anesthesia, lab, ra professionals particip Sen/ices may be pro	care professionals other than the one ordering the service may provide and bill for care. You can be provided by: other consultants requested by your physician, services may include but not limited adiology, etc. You can access information regarding the health benefits plans that these health care pate in on HMH-Bayshore Medical Center website at <a href="https://www.hackensackmeridianhealth.org">www.hackensackmeridianhealth.org</a> by by do not have internet information shall be provided to you upon request by HMH-Bayshore Medical Center.
amount, you should Medical Center, to th report this informatio	from in-network providers for more than your in-network copayment, deductible, and/or coinsurance report this information to your self-funded plan administrator and, if the bill is from HMH Bayshore be Department of Health at (800) 792-9770. If the bill is from a health care professional, you should not the appropriate professional licensing board in the Division of Consumer Affairs, Department of ty at (973) 504-6200.
	n in-network provider will not be more than any in-network copayment, deductible, per your health benefits plan.
	ect an out-of-network provider, you will be asked to sign an acknowledgement of out-of-network s, which may exceed your in-network copayment, deductible, and/or coinsurance amount.
coinsurance amount inadvertently or on a coverage for service:	or self-funded plan administrator for information regarding your copayment, deductible and/or and whether or not they have opted into in-network coverage for out-of-network services provided n emergency or urgent basis. Billing disputes with self-funded plans that have opted into in-network s rendered in an emergency or on an urgent basis may be resolved through arbitration. Contact ly found on the card provided to you by your self-funded plan.
	al Center staff will notify you in the event the in-network status of HMH-Bayshore Medical pre services are provided.
l agree that I have read and	understand this form and have been provided a copy of it.

Date

Patient's Signature