

www.hackensackmeridianhealth.org

FACILITY IN-NETWORK DISCLOSURE

Patient Name: _____ Health Benefits Plan: _____

| Patient Signature | |
|---|--|
| I agree that I have read and understa | and this form and have been provided a copy of it. |
| | dical Center staff will notify you in the event the in-network status of HMH-Jersey er changes before services are provided. |
| | enefits plan for information regarding your copayment, deductible and/or information is typically found on the card provided to you by your health benefits |
| | network provider, you will be asked to sign an acknowledgement of s, which may exceed your in-network copayment, deductible, and/or coinsurance |
| The amount you owe an in-netwo | vork provider will not be more than any in-network copayment, deductible, ealth benefits plan. |
| coinsurance amount, you sho HMH-Jersey Shore University N If the bill is from a health care p | enetwork providers for more than your in-network copayment, deductible, and/or could report this information to your insurance carrier and, if the bill is from Medical Center, to the Department of Health at (800) 792-9770. Professional, you should report this information to the appropriate professional of Consumer Affairs, Department of Law and Public Safety at (973) 504-6200. |
| facility. You can expect services include but not limited to anestr plans that these health care prowww.hackensackmeridianhealt | ssionals other than the one ordering the service may provide and bill for care in this is to be provided by other consultants requested by your physician, services may nesia, lab, radiology, etc. You can access information regarding the health benefits of provided in the service of the serv |
| | e professional, such as your doctor, or the physician assistant or advance practice s, to determine if they are in- network or out-of-network for your health benefits |
| | y Medical Center is in-network for the health benefits plan named above and your facility will be no greater than your in-network copayment, deductible, and/or |



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Patient Name: _____ Health Benefits Plan: _____

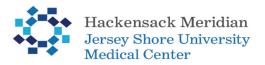
| Patient's Signature | Date | | - |
|--|---|---------------------------|---|
| | | | |
| I agree that I have read and | d understand this form and have be | en provided a copy of it. | |
| this facility. You can services may inclu health benefits pla Center website at | h care professionals other than the n expect for services to be provide de but not limited to anesthesia, lans that these health care professio | | |



www.hackensackmeridianhealth.org

SELF-FUNDED PLAN OUT-OF-NETWORK DISCLOSURE

| Patient Name: | Health Benefits Plan: |
|--|---|
| • HMH-Jersey Sho | e University Medical Center is out-of-network for the self-funded plan named above. |
| The total amount by your self-fur | 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-Jersey Shore University and what the HMH-Jersey Shore University 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 ba services render | 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 benefits plans to Center website in regard to you | 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 nat these health care professionals participate in on HMH-Jersey Shore University Medical at www.hackensackmeridianhealth.org . Services may be provided on an out-of-network basis relf-funded plan. If you do not have internet access, a copy of this information shall be upon request by HMH-Jersey Shore University Medical Center. |
| I agree that I have read | 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

Health Benefits Plan:

Patient Name:

| Patient's Signature | |
|--|---|
| I agree that I have read and understand this fo | orm and have been provided a copy of it. |
| HMH-Jersey Shore University Medical Cente Shore University Medical Center changes | r staff will notify you in the event the in-network status of HMH-Jersey before services are provided. |
| coinsurance amount and whether or not inadvertently or on an emergency or urgo coverage for services rendered in an em | dministrator for information regarding your copayment, deductible and/or they have opted into in-network coverage for out-of-network services provided ent basis. Billing disputes with self-funded plans that have opted into in-network the interpency or on an urgent basis may be resolved through arbitration. Contact I provided to you by your self-funded plan. |
| | k provider, you will be asked to sign an acknowledgement of out-of-network I your in-network copayment, deductible, and/or coinsurance amount. |
| The amount you owe an in-network provide coinsurance amount per your health ben | er will not be more than any in-network copayment, deductible, nefits plan. |
| amount, you should report this information University Medical Center, to the Depart | viders for more than your in-network copayment, deductible, and/or coinsurance on to your self-funded plan administrator and, if the bill is from HMH Jersey Shore ment of Health at (800) 792-9770. If the bill is from a health care professional, appropriate professional licensing board in the Division of Consumer Affairs, (973) 504-6200. |
| expect for services to be provided by: oth to anesthesia, lab, radiology, etc. You ca professionals participate in on HMH-Jers www.hackensackmeridianhealth.org | ther than the one ordering the service may provide and bill for care. You can her consultants requested by your physician, services may include but not limited n access information regarding the health benefits plans that these health care sey Shore University Medical Center website at Sen/ices may be provided on an out-of-network basis in regard to your net access, a copy of this information shall be provided to you upon request by enter. |
| | ssional, such as your doctor, or the physician assistant or advance practice ermine if they are in-network or out-of-network for your self-funded plan. |
| | nter is in-network for the self-funded plan named above and your financial eater than your in-network copayment, deductible, and/or coinsurance amount. |
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