

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

Patient Name:	Health Benefits Plan:	
<ul> <li>HMH-Mountainside Medical Center is in-network for the health benefits plan named above and your financial responsibility to this facility will be no greater than your in-network copayment, deductible, and/o coinsurance amount.</li> </ul>		
	are 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 Mountainside Medical Center	fessionals other than the one ordering the service may provide and bill for xpect services to be provided by other consultants requested by your ide but not limited to anesthesia, lab, radiology, etc. You can access alth benefits plans that these health care professionals participate in on HMH r website at <a href="www.hackensackmeridianhealth.org">www.hackensackmeridianhealth.org</a> . If you do not have internet ration will be provided to you upon request by HMH-Mountainside Medical	
and/or coinsurance amount, from HMH-Mountainside Med 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 dical 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-ne coinsurance amount per you	etwork provider will not be more than any in-network copayment, deductible, rhealth benefits plan.	
<ul> <li>If you specifically select an out-of-network provider, you will be asked to sign an acknowledgement of out-of-network provider services, which may exceed your in-network copayment, deductible, and/or coinsurance amount.</li> </ul>		
	benefits plan for information regarding your copayment, deductible Contact information is typically found on the card provided to you by your	
	nter staff will notify you in the event the in-network status of Center changes before services are provided.	
I agree that I have read and under	stand this form and have been provided a copy of it.	

Date

**Patient Signature** 



## **FACILITY OUT-OF-NETWORK DISCLOSURE**

Patient Name:	Health Benefits Plan:
• HMH-Mountainside	Medical Center is out-of-network for the health benefits plan named above.
-	ou owe may be more than the copayment, deductible, and/or coinsurance amount health benefits plan.
•	d the difference between what your health benefits plan pays HMH-Mountainside Medical s the HMH-Mountainside Medical Center charge for the services provided.
	the health care professional ordering the services to be provided in HMH-Mountainside Medica ne if he or she is in-network or out-of-network for your health benefits plan.
	your health benefits plan for information regarding your copayment, deductible and/or unt. Contact information is typically found on the card provided to you by your health benefits
this facility. You of services may income health benefits p website at www.	Ith care professionals other than the one ordering the service may provide and bill for care in an expect for services to be provided by: other consultants requested by your physician, ude but not limited to anesthesia, lab, radiology, etc. You can access information regarding the ans that these health care professionals participate in on HMH-Mountainside Medical Center tackensackmeridianhealth.org. If you do not have internet access, a copy of this information to you upon request by HMH-Mountainside Medical Center.
I agree that I have read a	nd understand this form and have been provided a copy of it.
Patient's Signature	Date



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

Patient Name:	Health Benefits Plan:
• HMH-Mountainside	Medical Center is out-of-network for the self-funded plan named above.
The total amount you self-funded plan.	owe may be more than the copayment, deductible, and/or coinsurance amount required by your
	the difference between what your self-funded plan pays HMH-Mountainside Medical Center and lountainside Medical Center charge for the services provided.
	our self-funded plan administrator for information regarding your copayment, deductible and/or nt. Contact information is typically found on the card provided to you by your self funded plan.
	ne health care professional ordering the services to determine if he or she is in-network or your self-funded plan.
into in-network co Billing disputes w	your self-funded plan administrator for information 'copayment regarding whether they have opted erage for out-of-network services provided inadvertently or in an emergency or on an urgent basis. In self-funded plans that have opted into in-network coverage for services rendered in an emergency sis may be resolved through arbitration. Contact information is typically found on the card provided funded plan.
expect for service limited to anesthe health care profewww.hackensack	h care professionals other than the one ordering the service may provide and bill for care. You can to be provided by: other consultants requested by your physician, services may include but not ia, lab, radiology, etc. You can access information regarding the health benefits plans that these sionals participate in on HMH-Mountainside Medical Center website at neridianhealth.org. Services may be provided on an out-of-network basis in regard to your f you do not have internet access, a copy of this information shall be provided to you upon request the Medical Center.
I agree that I have read a	l understand this form and have been provided a copy of it.
Patient Signature	Date



# SELF-FUNDED PLAN IN-NETWORK DISCLOSURE

Patient Name:	Health Benefits Plan:
	le Medical Center is in-network for the self-funded plan named above and your financial responsibility to be no greater than your in-network copayment, deductible, and/or coinsurance amount.
	act the health care professional, such as your doctor, or the physician assistant or advance practice ered the services, to determine if they are in-network or out-of-network for your self-funded plan.
expect for servi to anesthesia, l professionals p Sen/ices may b	ealth care professionals other than the one ordering the service may provide and bill for care. You can ces to be provided by: other consultants requested by your physician, services may include but not limited ab, radiology, etc. You can access information regarding the health benefits plans that these health care articipate in on HMH-Mountainside Medical Center website at <a href="https://www.hackensackmeridianhealth.org">www.hackensackmeridianhealth.org</a> e provided on an out-of-network basis in regard to your self-funded plan. If you do not have internet of this information shall be provided to you upon request by HMH-Mountainside Medical Center.
amount, you sh Medical Center report this infor	bills from in-network providers for more than your in-network copayment, deductible, and/or coinsurance ould report this information to your self-funded plan administrator and, if the bill is from HMH Mountainside, to the Department of Health at (800) 792-9770. If the bill is from a health care professional, you should mation to the appropriate professional licensing board in the Division of Consumer Affairs, Department of Safety at (973) 504-6200.
	owe an in-network provider will not be more than any in-network copayment, deductible, nount per your health benefits plan.
	y select an out-of-network provider, you will be asked to sign an acknowledgement of out-of-network vices, which may exceed your in-network copayment, deductible, and/or coinsurance amount.
coinsurance an inadvertently or coverage for se	ct your self-funded plan administrator for information regarding your copayment, deductible and/or nount and whether or not they have opted into in-network coverage for out-of-network services provided on an emergency or urgent basis. Billing disputes with self-funded plans that have opted into in-network ervices rendered in an emergency or on an urgent basis may be resolved through arbitration. Contact provided on the card provided to you by your self-funded plan.
	Medical Center staff will notify you in the event the in-network status of HMH-Mountainside nanges before services are provided.
I agree that I have read	d and understand this form and have been provided a copy of it.

**Date** 

Patient's Signature