

HMH - Palisades Medical Center 7600 River Road North Bergen NJ 07047 - 201.854.5000

www.hackensackmeridianhealth.org

FACILITY IN-NETWORK DISCLOSURE

Patient Name:	Health Benefits Plan:
	etwork for the health benefits plan named above and your financial no greater than your in-network copayment, deductible, and/or
	essional, such as your doctor, or the physician assistant or he services, to determine if they are in- network or out-of-network
care in this facility. You can expect ser physician, services may include but no information regarding the health bene Palisades Medical Center website at y	s other than the one ordering the service may provide and bill for rvices to be provided by other consultants requested by your ot limited to anesthesia, lab, radiology, etc. You can access fits plans that these health care professionals participate in on HMH www.hackensackmeridianhealth.org . If you do not have internet libe provided to you upon request by HMH-Palisades Medical Center
and/or coinsurance amount, you shou from HMH-Palisades Medical Center, If the bill is from a health care profess	k providers for more than your in-network copayment, deductible, ald report this information to your insurance carrier and, if the bill is to the Department of Health at (800) 792-9770. ional, you should report this information to the appropriate vision of Consumer Affairs, Department of Law and Public Safety at
The amount you owe an in-network pr coinsurance amount per your health b	rovider will not be more than any in-network copayment, deductible, benefits plan.
	rk provider, you will be asked to sign an acknowledgement of the may exceed your in-network copayment, deductible, and/or
	plan for information regarding your copayment, deductible nformation is typically found on the card provided to you by your
HMH-Palisades Medical Center staff will Medical Center changes before service	notify you in the event the in-network status of HMH-Palisades es are provided.
I agree that I have read and understand this	s form and have been provided a copy of it.
Patient Signature	Date



HMH - Palisades Medical Center 7600 River Road North Bergen NJ 07047 - 201.854.5000 www.hackensackmeridianhealth.org

FACILITY IN-NETWORK DISCLOSURE

Patient Name: _____ Health Benefits Plan: _____

Patient Signature	Date
I agree that I have read and understand this form	n and have been provided a copy of it.
this facility. You can expect for services to services may include but not limited to a health benefits plans that these health c	other than the one ordering the service may provide and bill for care in to be provided by: other consultants requested by your physician, anesthesia, lab, radiology, etc. You can access information regarding the care professionals participate in on HMH-Palisades Medical Center ealth.org. If you do not have internet access, a copy of this information HMH-Palisades Medical Center.
	an for information regarding your copayment, deductible and/or on is typically found on the card provided to you by your health benefits
•	sional ordering the services to be provided in HMH-Palisades Medical twork or out-of-network for your health benefits plan.
	en what your health benefits plan pays HMH-Palisades Medical edical Center charge for the services provided.
 The total amount you owe may be more th required by your health benefits plan. 	nan the copayment, deductible, and/or coinsurance amount
HMH-Palisades Medical Center is out-of-n	network for the health benefits plan named above.
• HMH-Palisades Medical Center is in-ne	etwork for the health benefits plan named above and your financial



HMH - Palisades Medical Center 7600 River Road North Bergen NJ 07047 - 201.854.5000 www.hackensackmeridianhealth.org

FACILITY IN-NETWORK DISCLOSURE

Patient Name:	Health Benefits Plan:
HMH-Palisades Medical Center is in-network	for the health benefits plan named above and your financial
HMH-Palisades Medical Center is out-of-network for	or the self-funded plan named above.
• The total amount you owe may be more than the c by your self-funded plan.	opayment, deductible, and/or coinsurance amount required
You may be charged the difference between what you and what the HMH-Palisades Medical Center charges.	your self-funded plan pays HMH-Palisades Medical Center arge for the services provided.
	ator for information regarding your copayment, deductible is typically found on the card provided to you by your self
You should contact the health care professional order- out-of-network for your self-funded plan.	dering the services to determine if he or she is in-network or
have opted into in-network coverage for out-of-ne on an urgent basis. Billing disputes with self-fund	rator for information 'copayment regarding whether they etwork services provided inadvertently or in an emergency or led plans that have opted into in-network coverage for ent basis may be resolved through arbitration. Contact d to you by your self-funded plan.
You can expect for services to be provided by: of include but not limited to anesthesia, lab, radiolog benefits plans that these health care professional www.hackensackmeridianhealth.org. Services	n the one ordering the service may provide and bill for care. her consultants requested by your physician, services may gy, etc. You can access information regarding the health Is participate in on HMH-Palisades Medical Center website at may be provided on an out-of-network basis in regard to your ess, a copy of this information shall be provided to you upon
I agree that I have read and understand this fo	orm and have been provided a copy of it.

Date

Patient Signature



HMH - Palisades Medical Center 7600 River Road North Bergen NJ 07047 - 201.854.5000

www.hackensackmeridianhealth.org

FACILITY IN-NETWORK DISCLOSURE

Patient Name:	Health Benefits Plan:
• HMH-Palisades Medical Cen	ter is in-network for the health benefits plan named above and your financial
	in-network for the self-funded plan named above and your financial responsibility to this ur in-network copayment, deductible, and/or coinsurance amount.
	re 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 self-funded plan.
expect for services to be provide to anesthesia, lab, radiology, etc professionals participate in on HI Sen/ices may be provided on ar	sionals other than the one ordering the service may provide and bill for care. You can ed by: other consultants requested by your physician, services may include but not limited. You can access information regarding the health benefits plans that these health care MH-Palisades Medical Center website at www.hackensackmeridianhealth.org nout-of-network basis in regard to your self-funded plan. If you do not have internet on shall be provided to you upon request by HMH-Palisades Medical Center.
amount, you should report this ir Medical Center, to the Departme	work providers for more than your in-network copayment, deductible, and/or coinsurance information to your self-funded plan administrator and, if the bill is from HMH Palisades ent of Health at (800) 792-9770. If the bill is from a health care professional, you should propriate professional licensing board in the Division of Consumer Affairs, Department of 504-6200.
 The amount you owe an in-network coinsurance amount per your he 	k provider will not be more than any in-network copayment, deductible, ealth benefits plan.
	f-network provider, you will be asked to sign an acknowledgement of out-of-network y exceed your in-network copayment, deductible, and/or coinsurance amount.
coinsurance amount and whethe inadvertently or on an emergenc coverage for services rendered i	d plan administrator for information regarding your copayment, deductible and/or er or not they have opted into in-network coverage for out-of-network services provided by or urgent basis. Billing disputes with self-funded plans that have opted into in-network in an emergency or on an urgent basis may be resolved through arbitration. Contact the card provided to you by your self-funded plan.
 HMH-Palisades Medical Center sta Center changes before services 	aff will notify you in the event the in-network status of HMH-Palisades Medical are provided.
I agree that I have read and understan	nd this form and have been provided a copy of it.

Date

Patient's Signature