



JFK Medical Center
65 James St, Edison, NJ 08818

Billing & Insurance
732-321-7000 x 65508

ACKNOWLEDGEMENT OF REQUEST FOR OUT-OF-NETWORK
PROVIDER SERVICES

Patient Name: _____ HAR #: _____

Reg. Date/Time: _____ MR #: _____

I, _____ have been informed that the hospital
named above is **outofnetwork** with my health insurance plan and further:

- ✓ My potential financial responsibility may exceed my copayment, deductible or coinsurance with my health insurance plan.
- ✓ I may be responsible for any excess amount above the allowed amount the health insurance plan pays or reimburses the provider for healthcare services I received; and
- ✓ I should contact my health insurance plan to identify the specific potential costs for which I am/may be responsible.

I acknowledge that I am **knowingly and voluntarily** accepting responsibility for any out-of-network financial responsibility associated with healthcare services that I receive.

Patient Name (Print)

Patient Signature

Date signed: _____

Witness's Name (Print)

Witness's Signature

Date signed: _____