

Agreement of Financial Responsibility – Medicaid



Patient Name Last, First, Mi	Date of Birth (Mo/Day/Yr)	Medicaid ID #
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Section 1 (Provider completes this section)

Description of non-covered service(s), for which the patient agrees to accept financial responsibility:

Expected cost of non-covered service(s) \$ _____

Expected date of service ____/____/____

The provider of services, _____, certifies that this office has an established policy for billing all patients, for services not covered by a third party. In accordance with state Medicaid provider billing guidelines, the patient has been advised prior to services being rendered the specific non-covered services(s) to be provided and the expected cost.

Completed by (print) _____ for the above provider.

Signature: _____ Date _____

Section 2 (Patient or responsible party completes this section)

I am the patient or responsible party. I understand my health plan may not pay for the services described in Section 1. I have been told what the expected cost will be. I have been informed and have signed this agreement before receiving the described services. I have been told why I may be billed and agree to pay the bill as described in Section 1.

Signature of Patient or Responsible Party: _____ Date _____

Responsible Party, if other than patient (print): _____

Relationship to Patient: _____