Patient acknowledgment of financial responsibility

Priority Health
1231 East Beltline NE
Grand Rapids, MI 49525

I hereby authorize: _____
Print physician's name

of: _____
Address, city and state

to perform the following medical service(s):

_____
Description of service

on: _____
Date of service

Name of Primary Care Physician at time of service: _____

For all products (except Medicare*):

☐ I understand this service(s) has not been authorized and I will be responsible for payment.

☐ I have contacted my Primary Care Provider (PCP) to obtain an authorization for this service. I understand that if my PCP or the health care plan deny my request, I will be responsible for payment.

For non-covered services, all products (except Medicare*):

☐ I understand this service(s) may not be covered by my health care plan, and I will be responsible for payment.

_____ _____
Member signature Date

Note: This form must be completed and signed at each visit.

**For Medicare members, use the form "Notice of Medicare Non-Coverage".*