St. Elizabeth's Medical Center
A STEWARD FAMILY HOSPITAL

Steward

Patient Financial Responsibility Managed Care Waiver Form

As a member of a managed care plan, I understand that all my medical care is to be coordinated by my Primary Care Physician (PCP), subject to any exception in my member agreement.

I acknowledge that if I do not have a valid referral from my PCP, including an authorization number required, for the specialty care I am about to receive, I will be responsible for payment of services received, if the payment is denied on that basis by my health insurance company.

I also understand that it is my responsibility to ensure that the service I am about to receive is a covered benefit by my health insurance member agreement. If the service is not a covered benefit, I will be responsible for payment of these services.

The above is subject to provisions of existing agreements between Steward Healthcare and my health insurance:

- ☐ HMO Blue
- ☐ Tufts Health Plan
- ☐ Harvard Pilgrim
- ☐ Other (specify) _____

Date of Service: _____

Patient Name (Print): _____

DOB: _____

Patient Signature: _____

Date: _____

I am a contracting provider for the above Managed Care Plan. However, I have not received a valid referral authorization and/or number from the patient's PCP or Health Insurance Company. This was communicated to the patient who agrees to assume financial responsibility for the services provided today, should the payment be denied by the health insurance, subject to provisions of existing agreement between Steward and the patient's health insurer.

Specialist Name (print): _____

PCP (print): _____

Office Staff Signature: _____