ProHealth™ PHYSICIANS
Part of OptumCare®

ProHealthMD.com

Notice of Financial Liability

Please read carefully.

Today's Date: _____

I understand that I have to pay for services not covered by my insurance if:

- ☐ The doctor/clinician does not accept my insurance. And, I did not get prior authorization (approval before getting medical services).
- ☐ My health plan reviewed the policy and this service does not meet the criteria.
- ☐ It was not clear if this service met the criteria when my health plan reviewed the policy. And, I did not get prior authorization.

	Procedure Codes	**Procedure Description**	**Diagnosis Codes**	**Procedure Cost Estimate**
1				
2				
3				

Date of Service: _____

Patient Name (Printed): _____

Patient Signature: _____

Member ID number: _____

This notice is valid only when the patient signs and receives a copy.