VANDERBILT UNIVERSITY
MEDICAL CENTER

ADVANCE NOTICE OF
FINANCIAL RESPONSIBILITY
FOR NON-COVERED ITEMS OR SERVICES
(NON-GOVERNMENT PAYORS)

The Vanderbilt Clinic
1301 Medical Center Drive
Nashville, TN 37232
Phone: (615) 343-7266

Patient Name: _____ **Identification Number:** _____

YOU NEED TO MAKE A CHOICE ABOUT RECEIVING THESE HEALTH CARE ITEMS OR SERVICES.

Vanderbilt University Medical Center (VUMC) expects your insurance company, _____, will not pay for the items or service(s) that are described below, because of historical information, the terms of your medical policy or other reasons. Your insurance company does not pay for all of your health care costs, such as non-covered items or services, items or services deemed by your insurance company as not medically necessary or experimental or investigational items or services. **The fact that your insurance company does not pay for a particular item or service does not mean that you should not receive items or services your physician has recommended.** Right now, in your case, VUMC DOES NOT EXPECT YOUR INSURANCE COMPANY TO PAY FOR:

Items or Services:	Reason Your Insurance May Not Pay:	Estimated Cost:
	☐ Non-covered item or service under your plan or policy	
	☐ Item or service exceeds limits of member benefit agreement	
	☐ Plan or policy has historically denied payment	
	☐ Experimental or investigational item or service	
	☐ Insurance company has deemed item or service not medically necessary	
	☐ Other	

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- ***Ask us to explain in case you don't understand why your insurance company probably won't pay.***
- ***Ask us how much these items or services will cost you, in case you have to pay for them yourself or through other insurance.***

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN AND DATE YOUR CHOICE.

Options:	**Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** **YES**. I want to receive these items or services listed above. I agree to be fully responsible for full payment for these items or services, and for any costs of collection, including without limitation, attorney's fees.	
☐ **OPTION 2.** **YES**. I want to receive the items or services listed above. I request that VUMC bill my insurance carrier for these items or services if appropriate, or to notify me if billing is inappropriate. I understand that VUMC may bill me for these items or services and that I may have to pay the bill while my insurance company is making its decision. If my insurance company pays, VUMC will refund to me any payments I made that are due to me or credit any of my outstanding account balances for which I am personally responsible. If my insurance company denies payment in full or in part, I agree to be fully responsible for full payment for these items or services, and for any costs of collection, including without limitation attorneys' fees.	
☐ **OPTION 3.** **NO. I have decided not to receive these items or services even though my physician has recommended it.**	
Signature of Patient:	Date:
Signature of Person Acting on Patient's Behalf:	Date:
Legal Relationship to Patient:	
Signature of Witness:	Date: