YourFLVoice
Insight from Your Insurance Consumer Advocate

You Could Be Signing Away Protections

While both the federal No Surprises Act and Florida law provide consumers with protection from surprise or unexpected medical bills, signing the Surprise Billing Protection Form may waive those protections. If the services you received are not within your health plan's network, you may be responsible for the full cost of medical procedures or treatment, or have to pay out-of-network pricing. Additionally, if multiple doctors perform services for you, you may be responsible for each provider's cost.

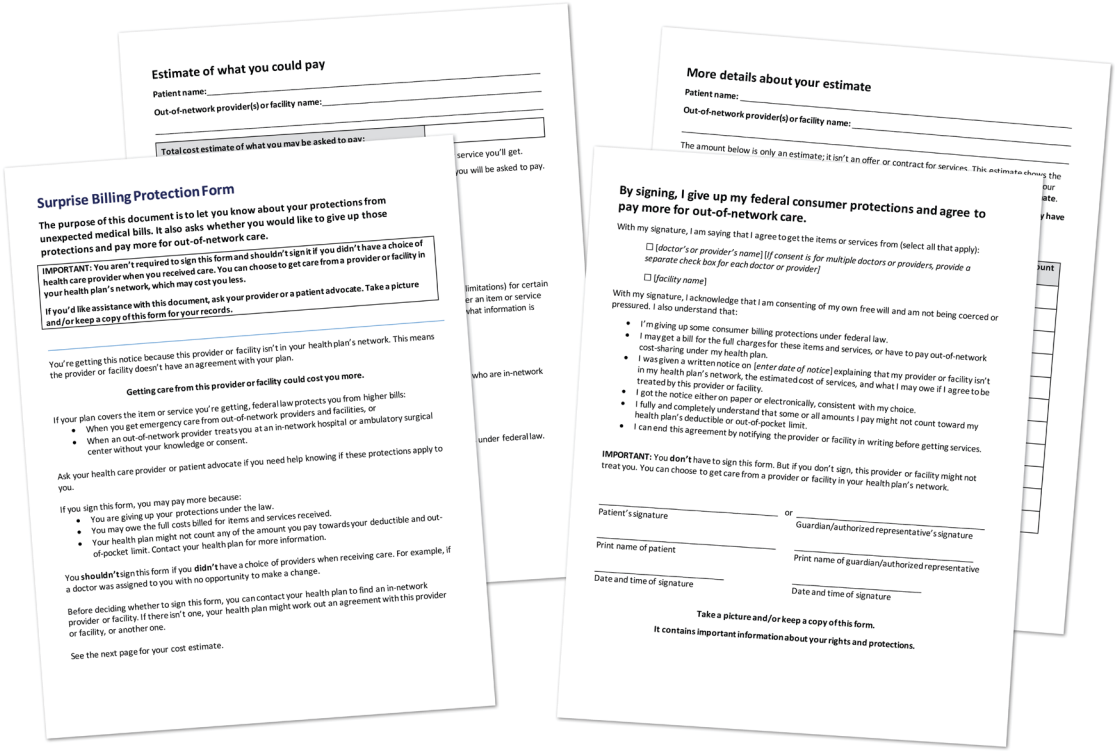
The Surprise Billing Protection form includes language that outlines what you may be forfeiting if signed. If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

The form may also include a cost estimate of what you are expected to pay. If you are uncomfortable with that amount, do not sign or agree to pay and contact your health insurance company for other options.

The Centers for Medicare and Medicaid Services advises that you are not required to sign the form and "…shouldn't sign it if you didn't have a choice of health care provider when you received care." However, the facility may decide not to treat you. "You can choose to get care from a provider or facility in your health plan's network, which may cost you less."

If you do sign the form, be sure to make a copy or take a picture for your records. Compare the estimate with the actual bill once received. You may end the agreement by notifying the facility in writing **prior to** receiving services.



Estimate of what you could pay

Patient name:

Out-of-network provider(s) or facility name:

Total cost estimate of what you may be asked to pay:

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

More details about your estimate

Patient name:

Out-of-network provider(s) or facility name:

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ *[doctor's or provider's name] [If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ *[facility name]*

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on *[enter date of notice]* explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

Patient's signature

or

Guardian/authorized representative's signature

Print name of patient

Print name of guardian/authorized representative

Date and time of signature

Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

Here is a **sample form**.

Please note, the version you receive may be included with other documents and may have a different title.

For more information on the federal protections, visit **www.CMS.gov/NoSurprises.**

To ask questions or file a complaint, contact the No Surprises Help Desk from 8 a.m. to 8 p.m. ET, 7 days a week @ 1.800.985.3059. You may also submit a complaint online.

For information on Florida law, review **s. 627.64194**, Florida Statutes. To file a complaint at the state level, contact the Department of Financial Services' Insurance Consumer Helpline @ 1.877.693.5236 or **online**.

www.MyFloridaCFO.com/Division/ICA

FLORIDA'S INSURANCE CONSUMER
ADVOCATE
FLORIDA DEPARTMENT OF FINANCIAL SERVICES

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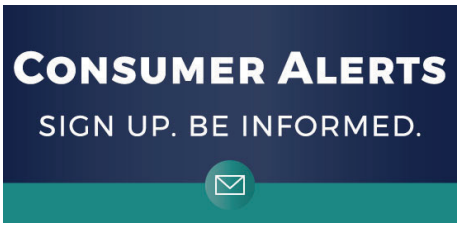

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