McLaren Business Products

McLaren Print System Order

Order No: 56831
Order Date: 2020-09-15
User: shirley liddell
Phone: 810-342-5333

Ship Location: Mclaren OakBridge Center PHP - Shirley Liddell
4448 Oakbridge
FLINT, MI 48532
Forms
Quantity: 500
Paragon Dept No: 43560
Dept Name: Mclaren OakBridge Center PHP
Company Number: 60

Order Total Price: 18.00

Item Number: M-1848
Item Description: Notice of Possible Financial Liability
Revision Date: 2/2015
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: 5 Hole Top
Misc Info:

McLaren Flint
PARTIAL HOSPITALIZATION PROGRAM

NOTICE OF POSSIBLE FINANCIAL LIABILITY

Dear: _____

The McLaren Flint Partial Hospitalization Program is operated by McLaren Flint. Because this facility is part of the hospital, we are required to file two claims to your insurance carrier(s): one claim for your visit to this hospital facility and a separate claim for the professional services of the physician who will be treating you.

Your insurance may require you to make a co-insurance payment for both this hospital visit and your physicians' professional services. Your actual coinsurance payment depends on the services you receive from this hospital facility and from the physician.

We are unable to determine the amount of your coinsurance payment responsibility for any services until we have billed and received payment from your primary and, if applicable, secondary insurance. Once McLaren Flint has received payment from all insurance carriers, two separate bills will be mailed to you: one from the hospital and one from the physician.

This letter is to advise you in advance that you will receive two separate bills for today services and any others associated with your current course of treatment for your coinsurance payment and deductible responsibilities.

For questions regarding your McLaren Flint bill, please contact Patient Accounts at (810) 342-2219.

Sincerely,
McLaren Flint

Signature of Program Representative: _____ Date: ____/____/____

I have read the above and understand that I may receive two separate bills for today's services and any other associated with my current course of treatment.

Signature of Patient or Authorized Representative: _____ Date: ____/____/____

Spec Info:

NOTICE OF POSSIBLE FINANCIAL LIABILITY
8730