Surgeons Surgery Center

Benefits Election Letter

Date:_____

To whom it may concern:

This letter shall serve as notice that I am electing to engage my “Out of Network” medical benefits which may require an informed disclosure by my medical provider.

Since I have paid a higher premium for the ability to seek an “Out of Network” provider, I wish to have my provider compensated for any and all treatments/procedures which he/she believes to be medically necessary to treat my existing condition/ailment/injury.

Please be advised that benefits have been check prior to receiving services, and if I do not receive an adverse benefit determination within 48 hours of the claims submission, I will assume all costs related to the treatment/procedure will be covered in their entirety as is states in my Summary of Benefits Coverage (SBC) documentation.

If an adverse benefit determination is received within 48 hours, please provide me with the entire claim file, including your copy of the SBC, that was utilized to make the determination so I can comply with the claims procedure process according the Patient Protection Affordable Care Act (PPACA) and the benefit plan in which I am enrolled.

Cordially,

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_____ _____ _____

Patients’ Signature Date Responsible Adult Companion