



**MEMBER CONSENT FOR FINANCIAL
RESPONSIBILITY FOR UNREFERRED/NON-COVERED SERVICES**
Applied to all benefit programs in New Jersey, Delaware and Pennsylvania

MEMBER INFORMATION

MEMBER NAME: _____

MEMBER'S ID #: _____

PROVIDER INFORMATION

PROVIDER NAME: _____

PROVIDER'S ID #: _____

SPECIALTY OR DEPARTMENT: _____

TYPE OF SERVICE: _____

MEMBER MUST COMPLETE THIS SECTION

As an AmeriHealth Member, I understand that...

(Check the appropriate box):

- A referral from my Primary Care Physician is required for any and all non-emergency outpatient hospital/ specialist services. I acknowledge that I do not have a referral with me at this time, but I choose to receive the services without the required referral. I understand that without the appropriate referral, I will be held responsible for any payments incurred for these services. (AHMO)
- I understand that this is a non-covered service for which my insurance carrier will not make payment and I agree to be financially liable for any payments incurred for these services. (ANY)
- I understand that certain services are not covered when performed in an office setting (i.e., radiology, DME). If I choose to receive these services in a provider's office, rather than the appropriate network setting, I agree to be financially liable for any payments incurred for these services. (ANY)
- I understand that I will be responsible for all fees incurred if this visit or any other service precedes the effective date that has been assigned to my enrollment or my dependent's enrollment. (ANY)

Member's Signature

Employer Name (if applicable)

Date

Employer Address (if applicable)

Witness / Office Staff

City State Zip