Health Care
University of Missouri Health System

Patient Name (Last, First, M)

Admission/Visit Number

UH MRN #

Arrival Date

UNIVERSITY OF MISSOURI HOSPITALS AND CLINICS
Patient Statement of Financial Responsibility

I recognize that I am financially responsible for today's charges for the following reason:

A. _____ I do not want any insurance billed for today's service.

B. _____ A referral or authorization was not obtained from my Primary Care Physician or health plan for today's service.

C. _____ My insurance company may deem today's visit non covered.

D. _____ I understand that University of Missouri Health Care does not participate with my Managed Medicaid plan and I will be financially responsible for today's charges. I understand that I could receive the services at no expense to me if I received them from an in network provider with my Managed Medicaid plan. I understand that University of Missouri Health Care will not bill my Managed Medicaid plan for out of network services. I will be financially responsible for payment for these services as a private pay patient.

E. _____ I understand that University of Missouri Health Care does not participate with Out of State Medicaid plans. I will be held responsible for today's charges.

Signature of Patient (Parent or Legal Guardian) // *Relationship to Patient* // *Date Signed*

Signature of Facility Representative // *Date Signed*

Submit

Revised 01/04/20