

OU MEDICAL CENTER

WRITTEN NOTICE OF MEDICARE/TRICARE BENEFICIARY'S FINANCIAL OBLIGATION

Dear Medicare/TRICARE Patient:

This department, the OU Breast Health Network, is a hospital outpatient department of OU Medical Center (the "Provider"). Because it is a hospital-based department that is located off the hospital campus, Medicare/TRICARE requires us to inform you that you will incur a coinsurance liability to the hospital that you would otherwise not incur if the services were furnished in an entity that is not hospital-based and to provide you with a notice of your potential financial liability for the hospital service(s).

At this time, we can provide you with the following information on the estimated amount of your coinsurance liability.

- Based upon current information regarding the type and extent of the services scheduled, your coinsurance liability for the hospital service(s) is estimated to be \$ _____; or,
• Since we are unable to predict in advance the exact type and extent of services you may need in your treatment plan, we are unable to provide you the exact amount of patient coinsurance liability. Typically patient coinsurance liability will approximate 20% of Medicare payment and the range of coinsurance liability is normally 100.00 to 1000.00 depending on the type and duration of your treatment.

The actual amount of your coinsurance liability to the hospital may be different from any estimate that is provided above. Actual coinsurance liability will be based on the services that you receive and also subject to final determination by the Medicare/TRICARE program.

If you are enrolled in a state medical assistance program such as Medicaid or Medi-Cal, your coinsurance liability may be reduced or eliminated by law.

Your coinsurance liability for hospital services is separate from the Medicare/TRICARE coinsurance liability that you may owe for any physician or professional services provided to you in conjunction with hospital services.

If the Medicare beneficiary is unconscious, under great duress, or for any other reason unable to read a Written Notice of Medicare Beneficiary's Financial Obligation statement and understand and act on his or her own rights, the notice is provided, prior to the delivery of services, to the beneficiary's authorized representative.

Beneficiary's Authorized Representative _____

In the event if the Medicare beneficiary is unconscious, under great duress, or for any other reason unable to read a Written Notice of Medicare Beneficiary's Financial Obligation statement and understand and act on his or her own rights, the notice is provided, prior to the delivery of services, to the beneficiary's authorized representative.

I acknowledge that I have read the foregoing and understand that I will incur a liability to the hospital for Medicare/TRICARE coinsurance as permitted by law and that I have received a copy of this notice.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Barcode area containing: ADMIN Page 1 of 1 EADMFO084 / Rev. Date, OU MEDICAL CENTER MEDICARE/TRICARE BENEFICIARY FINANCIAL OBLIGATION, and a box for Acct #, Loc, DOB, MR#.

Medicare Questionnaire:

Please answer the following questions to the best of your knowledge

1. Are you currently, or have you ever been, enrolled in a Hospice program? Y or N
2. Are you and/or your spouse(if applicable) currently retired? Y or N
If yes, self _____, spouse _____
Date of retirement? self _____, spouse _____
3. Reason for Medicare Eligibility: please circle a choice below
 - a. Age (65 and older)
 - b. Disability
 - c. End Stage Renal Disease (ERSD)
4. Have you had any outpatient hospital visits in the last 3 Days? Y or N
 - a. If yes, where? _____
5. Have you had any inpatient stays at a hospital in the last 60 days (2 months)? Y or N
 - a. If yes, where? _____
 - b. Admit date? _____
 - c. Discharge date? _____