Livingston HealthCare
Billings Clinic Affiliate

Livingston HealthCare Sleep Center
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Off Campus Medicare Outpatient Coinsurance Notice

To our Medicare patients:

Medicare regulations require us to provide you with a notice of your potential financial liability for the hospital service(s) you will receive. We are required to advise you that because the service(s) is/are furnished by a department of the hospital, 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. The professional component associated with your services are billed through Billings Clinic and you will receive a separate statement.

At this time, we can provide you with the following information on the estimated amount of your coinsurance liability. Your coinsurance liability for the hospital service(s) is estimated to be $_____ based on our current per visit estimate. This is 20% of estimated charges before any Medicare Supplemental Health Plans are considered.

Since we do not know the exact type and extent of services that you may need, we are unable to provide you with an estimate of your liability. However, the typical charge incurred by a beneficiary based on all visits to this department or facility normally ranges between $_____ and $_____ per visit.

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 program.

If you are enrolled in a state medical assistance program, such as Medicaid, your coinsurance liability may be reduced or eliminated by law. Your coinsurance liability for hospital services is separate from the Medicare coinsurance liability that you may owe for any physician or professional services provided to you in conjunction with hospital services.

I have read the foregoing and understand that I will incur a liability to the hospital for Medicare coinsurance as permitted by law.

_____ _____
Signature of Patient or Authorized Representative Date