Acknowledgement of Financial Responsibility Form

KEY MEDICAL GROUP, INC.
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HMO
Member Acknowledgement
of
Financial Responsibility

Provider: This form must be used for Blue Shield HMO members who wish to receive healthcare services from you that may not be covered by their Blue Shield HMO Benefit Plan.

Member: Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below if:

- the services are not covered under your Blue Shield HMO Benefit Plan or,
- the services have not been otherwise approved for payment by Blue Shield HMO.

Services: (Any service not described as a covered benefit in the member's Evidence of Coverage.)

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_____

_____

_____

_____
Member or Member's
Legal Representative Name (Please Print)

_____ Date: _____
Member or Member's
Legal Representative Signature

Provider: _____

_____

_____
Provider or Provider Representative Name
(Please Print)

_____ Date: _____
Provider or Provider Representative Signature

FOR QUESTIONS, CONTACT KEY MEDICAL GROUP AT (559) 735-3892