OHP Client Agreement to Pay for Health Services

This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000. Complete Section A if t~~T~~he client agrees to pay for service(s~~)~~ not covered by the Oregon Health Plan (OHP), the Oregon Health Authority (OHA) or OHA-contracted managed care entities (MCEs). Complete Section B if the client agrees to pay for service(s) that are covered by the OHP, OHA, or OHA-contracted MCEs.

SECTION A: Non-Covered Services – P~~p~~rovider section

① Provider completing this form is *(check one):*

☐ Rendering provider *(the person providing the service)* ☐ Prescribing provider

☐ Hospital ☐ Pharmacy ☐ Ancillary *(other)* provider:

② Services requested. These include, but are not limited to, treatment, equipment, supplies and medications.

Service codes *(CDT/CPT/HCPCS/NDC)*:

③ Expected date(s) of service *(if services will occur over several months, please say how often, with start and end dates):*

④ Condition being treated:

⑤ Estimated fees $ To $. *Check one of the following statements about these fees:*

☐ There are no other costs that are part of the service(s).

☐ There may be other costs. You may have to pay for them, too. Other costs may be for (*check all that apply):*

☐ Lab ☐ X-ray ☐ Hospital ☐ Anesthesia ☐ Other:

⑥ ☐ As the rendering or prescribing provider:

- I tried all reasonable covered treatments for your condition.
- I confirmed that the proposed service(s) are not covered for your condition.
- I informed you of covered treatments for your condition, and you chose a treatment that is not covered.

☐ As any other provider *(check one of the following statements):*

☐ I understand that your provider has talked with you about other choices and completed a separate *Agreement to Pay* form.

☐ Please see your provider to ask about other choices and to complete a separate *Agreement to Pay* form.

Provider name: NPI:

Provider signature: Date:

OHP client section

⑦ Client name: DOB: Client ID#:

⑧ I understand the following, and still choose to get the service(s) listed above:

- The services listed above are not covered for payment by OHP or my plan.
- If I get the services I agree to pay the costs. After having the services, I will get bills for them that I must pay.
- My other options, which are written on the back of this form and were explained by my provider.
- The medically appropriate treatment I can have, including services that OHA or my MCE may pay for.

Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* Date

If signed by the client's representative, print their name here:

⑨ Witness signature: Date:

Witness name:

This agreement is valid only if the estimated fees listed above do not change and the services are scheduled within 30 days of the member's signature.

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SECTION B: Covered Services – Provider section

① Provider completing this form is *(check one):*

☐ Rendering provider *(the person providing the service)* ☐ Prescribing provider

☐ Hospital ☐ Pharmacy ☐ Ancillary *(other)* provider: _____

② Services requested. These include, but are not limited to, treatment, equipment, supplies and medications.

_____

Service codes *(CDT/CPT/HCPCS/NDC):* _____

③ Expected date(s) of service *(if services will occur over several months, please say how often, with start and end dates):* _____

④ Condition being treated: _____

⑤ Estimated fees $ _____ To $ _____. *Check one of the following statements about these fees:*

☐ There are no other costs that are part of the service(s).

☐ There may be other costs. You may have to pay for them, too. Other costs may be for *(check all that apply):*

☐ Lab ☐ X-ray ☐ Hospital ☐ Anesthesia ☐ Other: _____

⑥ ☐ As the rendering or prescribing provider, I informed you of all of the following:

- That the proposed service(s) is covered by OHP and the appropriate payer (OHA, MCE, or third-party payer) may pay me, the provider, in full for the covered service; AND
- The estimated cost of the service, including all related charges, the amount that the appropriate payer may pay for the service, and that I may not bill you for an amount greater than the amount the appropriate payer may pay; AND
- That you knowingly and voluntarily agree to pay for the covered service(s).

☐ As any other provider *(check one of the following statements):*

☐ I understand that your provider has talked with you about your choices and completed a separate *Agreement to Pay* form.

☐ Please see your provider to ask about other choices and to complete a separate *Agreement to Pay* form.

Provider name: _____ NPI: _____

Provider signature: Date: _____

OHP client section

⑦ Client name: _____ DOB: _____ Client ID#: _____

⑧ I understand the following, and still choose to get the covered service(s) listed above:

- The service(s) listed above are covered for payment by OHP or my plan.
- I am knowingly and voluntarily agreeing to pay the costs for the covered service.
- I had an opportunity to ask questions, obtain additional information, and consult with my caseworker or client representative.
- I agree to privately pay for the service(s) by signing this *Agreement to Pay* form. I will get a copy of this signed agreement.

_____ _____

Client (or representative's) signature – *Representative must have proof of legal authority to sign for this client* Date

If signed by the client's representative, print their name here: _____

⑨ Witness signature: Date: _____

Witness name: _____

This agreement is valid only if the estimated fees listed above do not change and the services are scheduled within 30 days of the member's signature.

Attention OHP Client – Read this information carefully before you sign SECTION A.

Before you sign, you should be sure the service is not covered by OHP or your coordinated care organization (CCO) or managed care plan. Here are some things you can do:

① ***Check to see if the service is not covered***

OHA, your CCO, or plan will send you a Notice of Action if they do not cover a service that your provider requests. If you did not receive a Notice of Action, ask your CCO, plan or provider to send you one so you can be sure if the service is not covered by OHP.

② ***Request an Appeal and or Hearing if service is not covered***

Once you have a Notice of Action, you can request an Appeal or Hearing. Read the Notice of Action carefully. It will explain why the service was denied. It will also give you information about your right to appeal the denial or ask for a hearing. If you also have Medicare, you may have other Appeal rights. If you have both OHP and Medicare, call 800-Medicare (800-633-4227) or TTY 711.

③ ***Check to see if there are other ways to get the service***

Ask your provider if:

- They have tried all other covered options available for treating your condition.
- There is a hospital, medical school, service organization, free clinic or county health department that might provide this service, or help you pay for it.

Will your OHP benefits, or any other health insurance you may have, change soon? If so, try to find out if this service will be covered when your benefits change.

④ ***Ask about reduced rates and discounts***

Ask your provider if they can offer you a reduced rate for the service or if they offer discounts for people who pay for services privately. They may have nothing to offer you, but you won't know unless you ask.

⑤ ***Get a second opinion***

You may find another provider who will charge you less for the service.

Additional costs

There may be services from other providers – like hospital, anesthesia, therapy or laboratory services – that go with the service you want. You will have to pay for these, too. Ask your provider for the names and phone numbers of the other providers. Contact those providers to find out what their charges will be.

Questions?

- Call your plan or CCO's Customer Service department, or
- Call the OHP Client Services Unit at 800-273-0557, TTY 711
- Call the Public Benefits Hotline at 800-520-5292 for legal advice about OHP benefits and paying for services.

Attention Provider – Relevant Oregon Administrative Rules (OARs)

Requirements of this Agreement are outlined in OAR 410-120-1280, Billing, and 410-141-3540, Member Protections. These rules can be found online at https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=87.