THE University of Vermont HEALTH NETWORK

MRN _____

Patient Name _____

111Colchester Avenue
Burlington, VT 05401

Date of Birth _____

Notice of Financial Responsibility to Medicaid Beneficiaries

VT Medicaid Provider # 0470003 NY Medicaid Provider # 00353851

Patient Name: _____ MRN: _____

Item or Service(s) being sought: _____

CPT/HCPCS (if applicable): _____ Estimated Cost: $ _____

The University of Vermont Medical Center is unwilling to bill or accept Medicaid payment for the above listed item(s) or service(s) because the service is not considered a covered Medicaid benefit. If you wish The University of Vermont Medical Center to provide the item or service you must accept full financial responsibility.

I understand and agree to be personally financially responsible for the item(s)/service(s) listed above and that I will be billed directly by The University of Vermont Medical Center. I also understand that The University of Vermont Medical Center will not bill Medicaid the item(s)/service(s).

Signature of beneficiary or legal representative: _____
(If legal representative, please note relationship.)

Date/Time: _____

Witness: _____ Date/Time: _____

Make three copies of signed document and distribute as follows:
1) patient's copy, 2) scan a copy into PRISM and 3) attach a copy for billing, if applicable