ADVANCED SURGERY CENTER OF NORTHERN UTAH

Out of Network Provider

Thank you for scheduling your procedure at ASCNU. Your physician designed this facility with you in mind, and recommends treatment here to provide you with the highest level of patient care. We are proud to serve you and are committed to meeting your healthcare needs in a state-of-the-art environment, with a first-rate staff and excellence in patient satisfaction.

Although ASCNU is not currently a participating provider with your Insurance Plan, we strive to give our patients the best possible value for their health care dollar. Please be assured that you will not incur any additional costs or penalties from using our facility. It is the policy of ASCNU to extend "in-network benefits" to all of our patients.

A member of our staff called you prior to surgery to discuss pre-operative orders and your insurance coverage. Since we are unable to determine the exact amount your insurance will cover prior to your procedure, we request a deposit of up to $500 of the estimated deductible plus the full estimated co-insurance on the date of service, which will be applied to the patient's total financial responsibility. We will submit a claim to your insurance company on your behalf, and once the claim has been processed by your insurance carrier, we will send you a bill for any remaining balance, based on the amount allowed by your insurance company and your in-network benefits. Our pricing is competitive, and the total out of pocket expenses will be approximately **the same, or less** than what you would pay at another facility.

Check Request Information

Your insurance company is assuming that since we are out-of-network with them, you are paying in full for your procedure today. The check that they send to you is "reimbursement" for that payment. Please open all mail from your insurance carrier as checks are attached to the bottom of the statements and may not look like a check.

When you receive the check and Explanation of Benefits (EOB) we ask that you endorse it over to ASCNU and mail/bring it to us. Please mail/bring it to us no later than 15 business days after receiving. **Also provide the copy of the EOB that accompanies the insurance check.** Providing a copy will allow us to properly credit your account, and make the necessary adjustment off of your bill to match your in-network benefits. After all adjustments are made, you will receive a statement from our billing company showing payments and balance due, if any.

ASCNU – 55 E Golf Course Rd. Logan, UT 84321

Failure to provide us with payment made by your insurance carrier on your behalf for today's procedure could result in the following:

(Initial)

_____ **May be reported to the proper authorities as insurance fraud and/or theft.**

_____ **Can be reported to the IRS as income you received.**

_____ **Could result in your owing the entire balance due for today's procedure.**

If you have any questions or concerns, please do not hesitate to call us:

- ASCNU: (435) 787-7190 Monday – Thursday 6am to 5pm and Friday 6am – 2pm
- Billing Office: (435) 310-5588 Monday - Friday 9am – 5pm

I acknowledge that I have received a copy of this letter and understand the information herein.

Patient/Legal Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Label