statement of financial responsibility

DuPage Medical Group
WE CARE FOR YOU

Patient name: ______________________________

Date of service: ______________________________ Patient D.O.B. ______________

Chart #: ______________________________

Dear Patient,

Welcome to DuPage Medical Group. Thank you for choosing us as your health care provided.

CPT Code	Description of services

I have been notified and understand that in my case, my insurance company will/may deny payment for the above mentioned service for the following reasons:

- ☐ No referral issued (or received) from my primary car physician (PCP).
- ☐ Routine physical examination, test or preventive screening.
- ☐ Services determined not medically necessary or not a covered benefit under my plan.
- ☐ This lab / radiology treatment or type of diagnostic test.
- ☐ Removal / treatment of benign, asymptomatic lesion(s).
- ☐ Cosmetic procedure(s).
- ☐ This many visits or treatments.
- ☐ This type of equipment or medication for my condition.
- ☐ Other ______________________________

Financial payment can be arranged by calling Customer Service between 8:00 AM to 12:00 PM and 1:00 PM to 4:30 PM Monday through Friday at 630 942 7998 to set up a plan.

Beneficiary agreement to pay:
Based on the above information, I agree to pay for all charges associated with services related to his visit, if my insurance company denies payment.

______________________________ ______________
BENEFICIARY SIGNATURE DATE

Although your physician has deemed these medical services necessary, your insurance company may decline payment based on their interpretation of “medical necessity”