Instructions for the balance billing waiver

For purposes of these instructions, "patient" means the consumer of the service or supplies or the patient's guardian or legal representative.

General instructions

- Give a copy of all pages of the balance billing waiver (Form AH025) to the patient before scheduling services or supplies.
- Type in the information needed for each fillable field. Do not write in by hand.
- Do not change the form, including the font style and size.
- Do not include these instructions with the form given to the patient.

Page 1, "Estimate of what you may pay" section:

In the field for "Out-of-network doctor or provider name," enter only one facility or provider / person's name. **Do not enter a group or practice name.**

Page 2, "Notice of my right to cancel" section:

- In the field for "You must notify the provider in writing at," enter a website, fax, or other secure method where the patient can send a cancellation notice. The transmission must be secure because the form has protected health information.
- In the field for "You must send the notice to the provider on or before," enter the date that is five business days from the date the form was signed by the patient.

Page 3 and copies of Page 3, "More details about your estimate" section:

- In the "Service or supply – code and name" column, enter only one service or supply per row. Also include the CPT code for that service or supply.
- In the "Amount to be billed" column, enter a good faith estimate of the amount you expect to bill the patient for the service or supply listed in that row.
- In the "You may need to pay" column, enter a good faith estimate of the amount the patient will need to pay out of pocket for the service or supply.
- The total at the bottom of Page 3 (or your last page if more space is needed) must match the total you entered on Page 1.

To learn more, see 28 Texas Administrative Code Sections 21.4901 to 21.4904.

TDI | Texas Department of Insurance

Do you agree to pay more for out-of-network care and give up important legal protections?

This doctor or provider is not in your health plan's network. This means the doctor or provider does not have a contract with your plan.

If the service or supply is medically needed:

- State law protects patients with some types of health plans from higher bills from out-of-network providers. If you sign this form, you lose the protection of the law.
- If you sign this form, you agree to pay up to the full billed charges for these services and supplies.
- Your health plan might not count the extra amount you pay toward your out-of-pocket limit.
- Before you sign this form, you can ask your health plan to find an in-network provider. If there isn't one, your health plan might work out an agreement with this provider or another provider.
- If you have a plan that is an HMO (health maintenance organization) or EPO (exclusive provider benefit plan), it may not pay anything for out-of-network services and supplies.
- You should **not** sign this form if you believe your case is an emergency.
- You should **not** sign this form if you did not have a choice of providers. For example, if a doctor was assigned to you.

Estimate of what you may pay

Patient name: _____

Out-of-network doctor or provider name: _____

The charges may change if the type or amount of services or supplies changes.

Total estimate of what you may need to pay (insurance will not cover):	**$**

► **Detailed estimate.** See Page 3 for the estimated charge for each service or supply you get.

► **Call your health plan.** Your plan may have better information about how much you may need to pay. You also can ask about your provider options.

► **Questions about your rights?** Call the Texas Department of Insurance at 1-800-252-3439 or go to www.tdi.texas.gov.

I agree to give up (waive) my rights for consumer protection

- I understand I am giving up some consumer protections under state law.
- I understand I may get a bill for up to the full billed charges for these services and supplies. (This is called balance billing.)
- I signed this form at least 10 business days before getting services or supplies.
- I understand I have 5 business days to cancel this agreement (see "Notice of my right to cancel" below). I also understand I can't cancel after I get the services or supplies listed on this form.
- I was able to get my questions answered before signing this form.

_____ or _____

Patient's signature | Guardian or legal representative's signature

_____ _____

Date of signature | Print the guardian or legal representative's name

Keep a copy of this form. It contains important information about your rights.

Notice of my right to cancel

You have 5 business days to cancel this agreement to give up (waive) your consumer protections.

To cancel:

- You must notify the provider in writing at: _____

  _____
- You may sign below or use any written statement that is signed and dated and states that you want to cancel.
- You must send the notice to the provider on or before:_____.

I wish to cancel this agreement

_____ or _____

Patient's signature | Guardian or legal representative's signature

_____ _____

Date of signature | Print the guardian or legal representative's name

If you cancel, keep a copy of your notice and proof that you sent it.

More details about your estimate

Patient name: _____

Out-of-network doctor or provider name: _____

The charges may change if the type or amount of services or supplies changes.

Date of service	Service or supply – code and name	Amount to be billed	You may need to pay
Total estimate of what you may need to pay (insurance will not cover):			