

Sample Statement of Understanding

If your office uses a different Statement of Understanding, it is only valid upon HNE's review and approval. This form is not applicable for Medicare Advantage Members. This form should only be used in one of the four circumstances described below:

**Member Assumption of Financial Responsibility for Medical Services
Statement of Understanding**

I understand that a Health New England provider may not require me to sign this Statement of Understanding as a condition of receiving services unless one or more of the following conditions exist on the date below (date services provided):

1. These services are normally provided by my primary care physician and I have decided to request services from the below named provider who is not my primary care physician.
or
2. These services exceed my benefit limitation.
or
3. These services are not covered services under my Plan.
or
4. These services have not received prior approval.

I acknowledge that I have voluntarily sought the services of *(name of provider)*

_____ who is an HNE participating provider. I accept full responsibility for paying for these services provided today by the above named provider. I understand that Health New England will not pay the provider, or reimburse me, for the cost of today's services, or any subsequent or ancillary medical services that the provider may order today on my behalf as a result of today's visit.

I understand that this Statement of Understanding is not an acceptance of financial responsibility for any services other than those services provided or ordered today.

Patient's Name *(please print or type)*

Patient's HNE ID Number

Patient's Signature

Today's Date

Parent/Guardian Signature
(if under 18 years of age)