



### Professional Out of Network Disclosure Notification

Patient Name: \_\_\_\_\_

MRN: \_\_\_\_\_

Visit/Account Number (HAR): \_\_\_\_\_

Primary Insurance Plan: \_\_\_\_\_

This letter is to inform you that the healthcare professional that your appointment is scheduled with today is **out of network with your insurance plan.**

- You should have contacted your insurance company to discuss out of network benefits, if any, and identify the specific potential out of pocket expenses as they will exceed out of pocket expenses for an in network practice/facility; and,
- You are responsible for any excess amount above the allowed amount your insurance plan pays or reimburses for the services.

Our website, [atlanticealth.org/OON](http://atlanticealth.org/OON), provides a list of participating insurance plans and other helpful resources.

**By signing below, you acknowledge receiving a copy of this disclosure.**

\_\_\_\_\_

**Patient Signature  
(or authorized representative)**

\_\_\_\_\_

**Relationship  
(if not patient)**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Time**