SUNY DOWNSTATE Health Sciences University

REQUESTS FOR RESTRICTION ON PHI PAID OUT OF POCKET

Patient Name: _____
Last Name First Name MI

Address: _____ Telephone: _____(home)

_____ _____ (cell)

_____ DOB: _____

1. Request applies to:

__ Inpatient: Admission date: _____Floor/ Unit: _____

__ Outpatient: Date of Service _____ Clinic/ Area: _____

2. Description of services(s)/ item(s) being paid out of pocket:

Services:	**Items:**
_____	_____
_____	_____
_____	_____

3. Name of health plan restricting disclosure to: _____

4. Payment methodology: ___ Cash ___Check ___ Credit Card

By signing below, I certify that I am paying for the service(s)/ item(s) listed above out of pocket, in full, and as such, I am requesting that SUNY Downstate Health Sciences University- University Hospital of Brooklyn restrict the disclosure of this information to the health plan noted above. I understand that if my payment is declined, SUNY Downstate will make reasonable efforts to contact me for an alternate payment methodology, but will not be responsible for honoring this request if it does not receive timely payment. I also understand that this request does not apply to disclosures made by SUNY Downstate to other external health care providers for my treatment and that I am required to request separate restrictions with those providers. Furthermore, I understand that for future follow up visits which require the disclosure of the information restricted above to the health plan in order to determine the medical appropriateness of the follow up visit, I will be given an opportunity at that time to place a new restriction on the entire follow up visit and to pay out of pocket accordingly.

_____ _____
Print Name of Patient/ Personal Representative Signature of Patient/ Personal Representative

_____ _____
Description of Personal Representative's Authority Date

FOR SUNY DOWNSTATE HOSPITAL FINANCE USE ONLY:

___Approved; Paid in full
___ Denied; Reason for denial:

___ Payment declined, date(s) attempted to contact patient: _____
___ Service/ item cannot be unbundled & patient is unable to pay for entire bundle
___ Patient made request after provision of services or after pre- certification occurred and disclosure was already made to the health plan
___ Follow up visit requires information for medical necessity & patient unable to pay follow up visit
___ Disclosure is required under law

_____ _____ _____
Hospital Finance Representative Name Hospital Finance Representative Signature Date