

Member Liability Payment Policy

Policy

Members can only be held liable for non-covered services if they agreed to pay for the non-covered service by signing a valid waiver accepting financial responsibility acknowledging the services are non-covered. The waiver must clearly demonstrate that the member agreed in writing and in advance to pay for those services after being informed. A general member statement agreeing to pay for services not paid by the insurer is not sufficient.

Unless otherwise stated in the provider contract, contracted providers must advise a member in writing prior to the provision of services that the service(s) not covered by the plan will be the member's financial liability. Unless explicitly classified as a non-covered service in the member's Evidence of Coverage (EOC), the Plan must make a determination of non-coverage prior to the member being billed. Non-covered services may include self-referrals to specialists for services that require a primary care physician (PCP) referral or plan prior authorization.

A sample waiver is amended to this policy. In order to seek payment from the Plan member, the provider must retain and be able to produce documentation demonstrating that a valid member waiver of liability was obtained.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	10/01/2002
Previous revision date(s):	03/19/2003, 3/31/2004, 03/15/2006, 3/14/2007 05/01/10 - moved to new template, added sample liability waiver for providers to use. 11/01/2015 - Annual review and moved to new Plan template. 09/01/2016 - Annual review.
Connection date & details:	July 2017 – Annual review. July 2018 – Annual review, no updates. October 2019 – Updated notice of financial liability.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.

Notice of Financial Liability

Please read carefully.

Date: _____

Your signature below indicates that you understand that if you receive a non-covered service

from _____ **you will be financially**
Provider name

responsible for the costs of the services.

Estimated charge for service: \$ _____

Name of the non-covered service: _____

CPT/HCPCS code: _____

Patient signature: _____ Date: _____

Print name: _____ Member ID number:

This notice is valid only when the member signs and receives a copy.