Sample Notice and Consent Form

Form Used to Waive Surprise Billing Rights Under the No Surprises Act

Under certain circumstances, an out-of-network provider or facility is allowed to ask a consumer to waive their surprise billing protections under the No Surprises Act so the provider may balance bill the consumer.* In such circumstances, the consumer may agree to receive out-of-network services and pay more than their in-network cost sharing for rendered services.

For a consumer to waive surprise billing protections (for items and services that are eligible for waiver), the No Surprises Act allows the provider or facility to give the consumer a notice and consent form to ask the consumer to waive the protections. The notice and consent form must meet certain requirements, as reflected in the notice and consent form prepared by the federal government. Providers and facilities are required to use the federal notice and consent form unless a state develops a notice and consent form that meets the federal requirements.

To see when notice and consent to waive surprise billing protections is allowed, see When the Notice and Consent Exception Applies and When it Doesn't: Guidelines for Use. **Consumers are not required to waive their rights to protections under the No Surprises Act**. However, if they do not agree to waive their rights (where waiver is permitted), they may be required to reschedule care with an in-network provider.

Notice and consent is **NEVER** allowed when an out-of-network provider or facility is providing emergency services before a patient is stabilized. Additionally, the notice and consent exception is not applicable with respect to some non-emergency items or services, including ancillary services, and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

See the Decision Tree: Notice and Consent for the notice and consent form requirements and information on how and when the form must be shared with the consumer. A provider may not balance bill or apply out-of-network cost-sharing to a consumer if the consent form does not meet the federal requirements, **even if the consumer signs it**.

Notice and Consent Must Be Completed Within Certain Timeframes:

- For an appointment scheduled at least 72 hours before the date that the items or services are to be furnished: the notice and consent documents must be provided at least 72 hours before the date of the appointment.
- For an appointment scheduled within 72 hours of the date the items or services are to be furnished: the notice and consent documents must be provided on the date the appointment is scheduled.
- If an individual receives the items and services on the same day that notice is provided: the notice and consent documents must be provided at least three hours prior to furnishing the relevant items or services.

* With respect to certain nonemergency services or certain post-stabilization services provided in the context of emergency care.

This document is intended to provide clarity to the public about requirements related to surprise billing. It does not have the force and effect of law.

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Sample Notice and Consent Form

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

Consumers are NOT required to sign the form. They do not have to waive their surprise billing protections.

You're getting this notice because this provider or facility isn't in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

Consumers can contact their health plan to find an in-network provider or ask for help with lowering the costs.

See the next page for your cost estimate.

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There are two versions of this form that could be used: a previous version that was only applicable in 2022, and a current version that can be used in 2022 and in later years. The example highlighted here is the 2022 and later form.

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Estimate of what you could pay if you give up your protections

Patient name:_____
Out-of-network provider(s)or facility name:_____
_____

Total cost estimate of what you may be asked to pay:	

►**Review your detailed estimate**. See Page 4 for a cost estimate for each item or service you'll get.

►**Call your health plan**. Your plan may have better information about how much you'll be asked to pay. You also can ask about what's covered under your plan and your provider options.

►**Questions about this notice and estimate?** Contact [Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]

►Questions about your rights? Contact [Insert contact information for appropriate federal or state agency. The federal phone number for information and complaints is: 1-800-985-3059]

Prior authorization or other care management limitations

[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.]

[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

Understanding your options

You can get the items or services described in this notice from the following providers who are in-network with your health plan:

More information about your rights and protections

Visit [Insert website describing federal protections, such as www.cms.gov/nosurprises/consumers] for more information about your rights under federal law.

2

The total estimated costs show what the consumer may be charged if they waive their surprise billing protections. This must include all items or services that an out-of-network provider or facility providing nonemergency or post-stabilization services expects to charge.

Providers and facilities must provide contact information for someone to answer questions about the notice and estimate.

When this form is used to waive surprise billing protections for post-stabilization services (following emergency care) furnished by a nonparticipating provider at a participating emergency facility, a list of in-network providers must be provided. If no in-network providers offering post-stabilization items or services are available, or this section of the form is otherwise left blank, the consumer may not be balance billed or assessed out-of-network cost sharing.

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By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care.

With my signature, I'm agreeing to get the items or services from (select all that apply):

☐ *[doctor's or provider's name] [If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ *[facility name]*

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services, or have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice on *[enter date of notice]* that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all of the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility that's in your health plan's network.

_____ or _____
Patient's signature — Guardian/authorized representative's signature

_____ _____
Print name of patient — Print name of guardian/authorized representative

_____ _____
Date and time of signature — Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

3

All providers asking the consumer to waive their surprise billing protections must be listed here.

Again, consumers do not have to waive their protections. However, the out-of-network provider might not agree to treat them if they do not sign the form. If that happens, the provider cannot charge the consumer for cancelling the appointment.

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More details about your total cost estimate

Patient name: _____

Out-of-network provider(s)or facility name:_____
_____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

Contact your health plan to find out if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

[Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.]

For each provider or facility described in the notice, fill-in the table below by completing each column for each item and service to be provided by the provider or facility. Add additional rows if necessary. If the notice is for more than one facility or provider, list items and services to be provided by the same facility or provider in adjacent rows, and provide a subtotal estimate for each facility and provider(s). If the notice is for one facility or one provider, the subtotal estimate may be omitted. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.]

Date of service	Name of Provider or Facility	Service code	Description	Estimated amount to be billed
Subtotal for [insert name of provider or facility]:				
Total estimate of what you may owe:				

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Each provider or facility asking the consumer to waive surprise billing protections must be listed.

This total should match the total on page 2 of the notice and consent form.

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