NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

PATIENT IDENTIFICATION

DO NOT BILL INSURANCE - PATIENT HIPAA RESTRICTION REQUEST

Name of Patient _____Date of Birth _____ MR # _____

Please do not share the health information specified below with my health insurance company:
Date of Service_____ Clinic or Department Visited _____
Specific Service or Test to be Restricted:
_____
_____

Please provide the following information:
Name of Primary Insured _____
Name & Address of Health Plan _____
_____
Member ID # _____ Group # _____
Name of Person Responsible for Payment _____

Please read and sign below to let us know you received and understand this information.
In order to agree to your request, NCH requires the following:

- You must make this request when you register, *before* services have been provided.
- You must make the required estimated payment. This payment will be applied to your account. You will be billed for any money due or issued a refund.
- You must pay off the bill within 30 days from the date of your service(s).
- You must sign this form.

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Please note that:

- We are not able to honor this request if information has already been released to your health insurance company.
- We are not able to honor this request if you have not paid for all charges related to this request within 30 days from the date of your service(s). At such time, your information will be given to your health insurance company so that we may collect payment.
- You must provide your current insurance information. This information will only be used if you do not meet the 30 day payment deadline.
- Insurance companies often require pre-certification for certain services. By requesting this HIPAA restriction and choosing to self-pay for such a service, you waive your right to obtain a pre-certification. If you do not meet the 30 day payment deadline, we will try to collect payment from your insurance company. However, failure to get a pre-certification may result in the insurance company refusing to pay your claim in which case you will be responsible for the total balance due.
- We are not able to apply a restriction if a pre-certification was already obtained before you made your request.
- Restrictions are granted one visit at a time. You must request a restriction for each visit. It is your responsibility as the patient to request another restriction for visits with future providers and/or visits related to follow-up treatment.
  - o If an additional restriction is not made, NCH is allowed to give previously restricted protected health information to your insurance company so that your follow-up treatment visits can be proven as medically necessary.
  - o If your insurance company refuses to pay your claim because medical need was not proven before services were originally provided, you will be responsible for all charges they will not pay.
- We do not have the ability to separate services which are billed together as a bundle. If during your visit, you request to restrict only one of a few services which are bundled together for billing purposes, you will be required to pay out of pocket for the entire bundle of services received.
- The charges related to this request must be paid in full and will not qualify for financial aid.
- NCH is allowed to disclose protected health information as required by law.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature Date/Time