ARTHRITIS & RHEUMATOLOGY OF GA

2020 Infusion Financial Responsibility Form

MR#_____ Date:_____

Patient's Name:_____

Drug:_____ Doctor:_____ Verified by:_____

Primary:_____ ID#_____Co-Pay $_____

Deductible:_____ Met:_____ Ins %:_____ Pt %:_____

Out of Pocket Max:_____ Met:_____

Authorization Required? ☐ Yes ☐ No

Secondary:_____ ID#_____Co-Pay $_____

Deductible:_____ Met:_____ Ins %:_____ Pt %:_____

Out of Pocket Max:_____ Met:_____

Authorization Required? ☐ Yes ☐ No

Does secondary cover primary's deductible? ☐ Yes ☐ No

Pan Form___ Copay card on file/agreement_____ Infusion Policy___ Exchange Plan Policy____

Below is an estimation of your financial responsibility, however, this is not a guarantee of insurance payment. Your responsibility may be more or less. This is an estimation of cost based upon information we received from your insurance company. We are unable to determine the exact amount until payment is received from your insurance company. Balances may NOT be carried in the infusion department. Any estimated patient responsibility MUST be paid on date of service.

Your estimated financial responsibility **before** deductible is met.	Your estimated financial responsibility **after** deductible is met.
$_____ drug copay with card $_____ estimated co insurance $_____ co pay	$_____ drug copay with card $_____ estimated co insurance $_____ co pay
$_____ total estimated infusion	$_____ total estimated infusion

Patient's Signature_____

Date:_____