Fertility Centers OF ILLINOIS

Your Miracle. Our Mission.

PATIENT NAME _____
Last Name First Name

MPI # _____

Patient Financial Responsibility Notice
Insurance Change Form

Dear Patient,

Often a new year brings changes with personal insurance provider selections. This signed form will be required to be received by our scheduling staff by December 8, 2021, for any patient treatment services scheduled between the dates of December 13, 2021, and December 31, 2021.

Please note, treatment related appointments will not be scheduled after December 13th without a signed copy of this form on file.

Fertility Centers of Illinois will make our best effort to coordinate your care in a cost-effective manner within the limits of your insurance benefit, and to minimize the out-of-pocket expense which you are responsible for. Fertility benefits can and do vary widely by state, insurer, and specific plan. The coverage available to you depends on insurance choices you made with your employer or purchased independently.

Your insurance coverage is specified in a contract between you and the insurance company. Please note that we are not a party to your insurance contract. You are responsible for understanding the details of your insurance plan, and we rely on you to keep Fertility Centers of Illinois up to date with correct information about your coverage.

Please select only one of the options below that applies to you:

_____ ☐ **I elected the same insurance plan for 2022 that charges were billed to in 2021.**

Initial

Covered services can change year-to-year even though your plan (or group number) doesn't. Fertility Centers of Illinois encourages you to independently confirm the exact extent of coverage of benefits and request evidence of coverage with your insurance carrier and your employer.

_____ ☐ **I elected a different insurance plan for 2022 that charges were billed to in 2021.**

Initial

Authorization requirements vary by insurance plans. Please complete the information below. Your insurance election for 2022 will influence our ability to obtain authorizations when required. In some circumstances, you may not be eligible to proceed with services from December 13th through December 31st dependent on meeting your newly elected insurance plan authorization criteria.

New 2022 Insurance Company: _____

Subscriber: _____ **Subscriber Relation to Patient:** _____

Subscriber ID: _____ **Group #:** _____

Is this an employer sponsored policy ☐Yes ☐No

If yes, is the employer's headquarters located in Illinois? ☐Yes ☐No

All patients will be required to provide a valid insurance card or other evidence of coverage at the time of service. If a card is unavailable at the time of your first service(s) in 2021, please call your insurance provider in advance of your appointment and obtain the information above to bring to your appointment. Additionally, you may be asked to pay a deposit if your coverage has a deductible greater than $1000, you have limited coverage, or you have no coverage for infertility.

I have read and understand the policy outlined above and agree to accept full financial responsibility as described. I authorize payment to Fertility Centers of Illinois of insurance benefits for claims submitted on my behalf and I also authorize Fertility Centers of Illinois to release any medical information necessary for claim payments. Patients who are married or in a legal union are jointly responsible for all charges incurred.

Patient Signature: _____ **Date:** _____

PLEASE EMAIL THIS FORM TO: fciprecertfax@fcionline.com or FAX it to 847-832-6866