



Request for Restrictions on Use and Disclosure of PHI to Payor
(Self-Pay Restricted Processing – for UnityPoint Health use only)

Patient Information:

****Affix Patient Label Here****

Request to Self-Pay for Services instead of Filing Insurance Claim for Payment

I hereby request that **UnityPoint Health** not submit a claim to my insurance company for the date/type of service indicated below. Subject to the limitations set forth below, I understand that if I pay UnityPoint Health such services as described below under “Terms of Payment”, UnityPoint Health will not bill my insurance company. **If the services are not paid as described below, a claim will be submitted to my insurance company.**

Date of Service: _____

Services Provided: _____

Insurance Company and ID #: _____

Patient Address: _____

*****Guarantor address and information must be correct on the account!*****

Terms of Payment: Patient must pay a deposit of \$_____ at the time of service and pay statement balance within 30 days of the billing date. **If payment in full is not made within 30 days of billing date, the full charges and related protected health information for that visit may be submitted to my insurance company.**

Limitations on Agreement to Self-Pay Restricted:

This agreement not to bill my insurance, if I meet the Terms of Payment, **applies only to UnityPoint Health, and not to the independent physicians and other providers who may have provided services to me while at UnityPoint Health. This may include services such as laboratory, radiology, anesthesia, test interpretations, etc. I understand I must contact those other providers directly and agree to their payment terms if I do not want them to bill my insurance**

If your health plan is Medicare or Medicaid and you have made a restriction request for a service that is otherwise payable by such programs, UnityPoint Health is treating your request as a refusal to authorize our submission of a claim to Medicare or Medicaid on your behalf, even if you have signed other forms which include standard reassignment of Medicare claim language. Please note that if UnityPoint Health is required by law to subsequently disclose information to Medicare or Medicaid, UnityPoint Health will do so.

If during your service that is subject to this restriction your provider orders a prescription for you, you should ask the provider to provide you with a paper prescription to give to the pharmacy. Failure to



request a written prescription may result in the pharmacy receiving the electronic prescription and submitting it to your health plan prior to your arrival at the pharmacy. It is your obligation to request a restriction at the pharmacy at the time you present the written prescription. Failure to do so may result in the pharmacy billing your health plan for the prescription and your health plan may still be able to identify the item or service for which you requested a restriction.

If you require follow up care at a UnityPoint Health facility or by any UnityPoint Health clinician or pharmacy related to this same service, you must request a new restriction application to the follow up care and pay out of pocket for that service. If you do not, and UnityPoint Health is required to include information for the first visit as support for the medical necessity of the follow up care, information from your first visit will be disclosed to your health plan.

If UnityPoint Health receives an authorization to release health records that are otherwise subject to this restriction to your health plan that is signed by you and dated after the date of this restriction request, UnityPoint Health will assume you want us to release all information described in such authorization, including information subject to this restriction.

If your request relates to a broader episode of care and complying with your request results in UnityPoint Health not being legally permitted to bill the health plan for the broader episode of care without inclusion of the restricted information, UnityPoint Health will notify you and offer you the opportunity to pay for the broader episode of care, and if you do not do so, UnityPoint Health will not be able to honor your request for restriction.

I acknowledge that due to technology limitations, the medical records from this self-pay service may be embedded within other records in my medical record and may later be released to my insurance company with other records (e.g. records for quality review or for other visits).

Signature of Patient or Legal Representative:

Date:

X _____

Section to be completed by UPH STAFF:

Patient Access to complete- Received by: _____

Date: _____

UnityPoint Health Staff Instruction:

1. Once the patient has read and signed the document scan it into Epic with a document type of "Self-Pay Restricted" and add an account note using the "Self Pay Restriction" Smart Text
2. Set the "Release Restriction #2" FYI flag within Epic and select the Smart Text for "Self-Pay Restriction" and add an account note using the "Self Pay Restriction" Smart Text
3. If Epic already has the patient insurance information, please remove it from the Epic HAR/Visit Info record and select the "Do not bill insurance" check box
4. Attach a copy of both the front and back of the patient's insurance card to this patient signed document
5. Provide the patient a copy of the signed document

Use only if the patient wants to retract their request to not bill their insurance company

I hereby request and authorize **UnityPoint Health** to submit a claim to my insurance company for the date/type of service indicated above.

Signature of Patient or Legal Representative:

Date:

X _____
