**[Delaware Regulations](http://regulations.delaware.gov/default.shtml) :**[**Administrative Code**](http://regulations.delaware.gov/AdminCode/index.shtml)**:**[**Title 18**](http://regulations.delaware.gov/AdminCode/title18/index.shtml)

**1300 Health Insurance General Provisions**

**1317 Network Disclosure and Transparency**

Source: <http://regulations.delaware.gov/AdminCode/title18/1300/1317.shtml>

**APPENDIX 1 – FORM OF FACILITY-BASED PROVIDER DISCLOSURE**

Network Disclosure Statement for [Insert Facility Name]

PLEASE RETURN THIS FORM TO [INSERT FACILITY NAME]

ON OR PRIOR TO YOUR DATE OF SERVICE

 This Facility-Based Provider Disclosure is designed to help ensure that patients receiving medical care from [Insert Facility Name] or any of its facility-based providers have the necessary information to make an informed decision about their medical benefits and care. “Facility-based provider” means a provider who provides health care services to covered persons who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, or radiology.

 In connection with your upcoming scheduled appointment, [Insert Facility Name] hereby provides the following disclosures:

 1. [Insert Facility Name] [is / is not] a participating provider with your current health insurer.

 2. Certain facility-based providers may be called upon to render care to you during the course of treatment.

3. Those facility-based providers may not have a contract with your health insurer and are therefore considered to be out-of-network.

4. Services that are provided by an out-of-network provider will be provided on an out-of-network basis, **which may result in additional charges for which you may be responsible.** These charges are in addition to any coinsurance, deductibles and copayments applicable under your health insurance policy.

5. The following is a list of those facility-based providers that may be called upon to render care to you during the course of treatment. You should contact your health insurer to determine the network status of these facility-based providers:

 a. [Include list of relevant facility-based providers, including contact information]

 6. An estimate of the range of charges charged by an out-of-network provider for any out-of-network services for which you may be responsible may be requested from, and will be timely provided by, the out-of-network provider. The provision of the estimate of range of charges shall be considered timely if it is provided to the covered person within three (3) business days of such request if the medical necessity of a procedure allows such time, and if not, in as timely a manner as possible.

7. You may contact your health insurer for additional assistance or may rely on whatever other rights and remedies may be available under state or federal law.

8. A facility-based provider may not balance bill you for health care services not covered by your insurance policy if the facility-based provider fails to provide you with a copy of this Facility-Based Provider Disclosure and obtain your below-printed consent prior to rendering any services.

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PATIENT ACKNOWLEDGEMENT/CONSENT

 I hereby acknowledge that a provider rendering services to me may be an out-of-network provider and that the services provided by that out-of-network provider may not be covered by my insurance policy. I further acknowledge that I have been informed of my right to request from the out-of-network providers an estimate of the range of charges for any out-of-network services for which I may be responsible. **I affirmatively elect to obtain the services and agree to accept and pay the charges for the out-of-network services not covered by my insurance policy.**

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_