[**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 2 – FORM OF HEALTH CARE PROVIDER DISCLOSURE**

Network Disclosure Statement for [Health Care Provider]

PLEASE RETURN THIS FORM TO [INSERT HEALTH CARE PROVIDER NAME]

ON OR PRIOR TO YOUR DATE OF SERVICE

 This Health Care Provider Disclosure is designed to help ensure that patients receiving medical care from [Insert Health Care Provider Name] have the necessary information to make an informed decision about their medical benefits and care. “Health care provider” means any provider who provides health care services to covered person who are not in a facility-based setting, and includes a provider who provides health care services to a covered person based upon a referral from another provider without the knowledge of or input from the covered person.

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

 1. [Insert Health Care Provider Name] is not a participating provider with your current health insurer and, therefore, the services provided to you will be provided on an out-of-network basis.

 2. **Services provided on an out-of-network basis 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.

 3. The following is a list of the range of charges charged by [Insert Health Care Provider Name] for any out-of-network services for which you may be responsible:

 a. [Insert List of Range of Charges]

 4. 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.

 5. [Insert Health Care Provider Name] may not balance bill you for health care services not covered by your insurance policy if [Insert Health Care Provider Name] fails to provide you with a copy of this Health Care Provider Disclosure and obtain your below-printed consent prior to rendering any services.

PATIENT ACKNOWLEDGEMENT/CONSENT

I hereby acknowledge that [Insert Health Care Provider Name] may be an out-of-network provider and that the services provided by [Insert Health Care Provider Name] may not be covered by my insurance policy. I further acknowledge receipt 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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