ATTACHMENT 22

Private Pay Form

Today's Date:_____

Name:_____ DOB:_____

Address:_____

City: _____ State:_____

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the (Program Name) as being reasonable and medically necessary for my care. I understand that El Paso First through its contract with HHSC determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

Signature:_____ Date:_____