700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4000
F 866.572.4393
www.uhahealth.com

UHA Advance Financial Notice

Patient/Member Name: ______________________________

Aloha UHA Members:

To help you decide if you want the services, items or lab tests listed below:

- Please talk to your healthcare Provider or to us at UHA to see if you are covered **before** you receive the service.
- This way you will know if you are required to pay for the service provided.
- Keep in mind that UHA will pay **only** for services that are a plan benefit, and that meet UHA's payment standard.
- Please take time to review this notice with your healthcare Provider.

Please initial the box next to the service(s) that you agree to pay the Provider.
(For Provider: Use the lines below to list service, item or lab test, and charge for each service.)

Your initials	Service(s):	Estimated charge:

Your Co-Payment

UHA partners only with providers in the state of Hawaii. If you choose a Provider who does not work with UHA, **you will be responsible for the provider's charges in excess of UHA's payment.**

Member Agreement

This agreement is between you (the UHA member whose signature appears below) and your provider, whose name is stated below:

Provider Name ______________________________ UHA Provider ID No. ______________

By signing this Agreement, you understand UHA will probably not pay for the services, items or lab tests listed above. If UHA denies payment you must pay the provider's charge (estimated above).

"I understand that UHA may not pay for each service listed above because the service may not be a plan benefit or may not meet UHA's payment standard. If UHA denies payment for the service(s), I agree to pay the provider for services rendered.

Member Signature or Representative ______________________________ Date ____________ Time ____________

Provider Signature ______________________________ Date ____________