*Text of the Facility Fee Notice required by current Maryland law, Health General §19-349.2.*

# Facility Fee Notice

IMPORTANT FINANCIAL INFORMATION

(Patient Name)______________________ Appointment Date:____________________

Notice Of Hospital Outpatient Facility Fee And Billing Disclosure

a. Your appointment with (provider, practice, or outpatient facility name) will take place in an outpatient department of (hospital name).
b. (Hospital name) will charge an outpatient facility fee that is separate from and in addition to the bill you will receive from (provider).
c. You will receive two charges for your visit:
1. a provider services bill from (provider); and
2. a hospital facility bill from (hospital name).

Expected Fee

(if known) The amount of the facility fee that will be charged by (hospital name) for your appointment is $ ____________. or

(if unknown) (Hospital name's) facility fee is likely to range from $___________ to $_____________. and

(if unknown) Based on appointments like the one you are scheduled for, we estimate the facility fee to be $____________. and

(if unknown) We are providing you with a range of fees and an estimate because the actual amount of the facility fee will depend on the hospital services that are actually provided. The fee could be higher if you require services during your appointment that we cannot reasonably predict today.

Financial help for your portion of the outpatient facility fee bill may be available. If you need financial help with the outpatient facility bill, please contact (hospital financial assistance office, with telephone number and direct website address).

Receiving services here may result in greater financial liability than receiving services at a location where a facility fee may not be charged.

(if applicable) No Facility Fee Location

You can see (provider) at another location that does not charge a facility fee.

(address and contact information)

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Contact your insurance carrier to see if (provider) is a participating provider and in–network at the (address of alternative location) location.

Insurance Information

(1) The amount of the facility fee that you will be responsible for paying will depend on your insurance coverage.
(2) Insurance companies could impose deductibles or higher copayment or coinsurance amounts for services provided in hospital outpatient departments.
(3) If you have insurance, you should contact your carrier to determine your insurance coverage and your estimated financial responsibility for the facility fee, including copayments, coinsurance, and deductible amounts for the outpatient facility fee.

Facility Fee Complaints

If you have a complaint about an outpatient facility fee charge, please first contact the hospital, (hospital billing office contact information).

If the complaint is unresolved, you may then file the complaint with the Health Services Cost Review Commission, (contact information).

If you need additional information regarding your facility fee charges or if you need assistance mediating a facility fee complaint against a hospital, contact the Health Education and Advocacy Unit of the Office of the Attorney General, 1–877–261–8807 | Heau@oag.state.md.us | www.MarylandCares.org.

Acknowledgment

(1) I understand that I will be billed a hospital facility fee and a provider fee.
(2) (Hospital name) provided me with information on the facility fees that will be billed for my appointment.
(3) I understand that the fee could vary based on conditions and services provided to me that the hospital cannot reasonably predict today
(4) I understand that my out–of–pocket costs will depend on my insurance coverage.
________(initial here) – by initialing here, I confirm that I received the facility fee information at the time I made my appointment with (provider).

By signing this form, I acknowledge that I have received this information before receiving services today.

______________________________ ________________

Signature Date

To request this notice in an alternative format, please call (contact information) or e–mail (contact information).

(Same sentence in Spanish).