NY Orthopedics
130 East 77th Street, 5th Floor, William Black Hall
New York, NY 10075
Phone: Ext: * Fax:

Dear

Patient
Date of Surgery
Surgeon Steven J. Lee, M.D.
Insurance Carrier
Policy ID Number
Pre-Authorization Number

The purpose of this letter is to inform you of your Financial Responsibility that we gathered from your insurance carrier. We also want to reconfirm that we have the correct current insurance carrier and policy information on file.

Please note that the surgeon's charge does not include the hospital or anesthesia charges. We only verify your medical benefits coverage and eligibility. This does not guarantee that these benefits are the same as, or if it applies to, your hospital/facility coverage. We will also obtain the necessary pre-authorization for the surgery and the facility where the surgery will be done. The hospital/facility will call for their own verification of benefits coverage and eligibility.

According to your insurance company, you have a $ ___deductible. You will be responsible for ANY/ALL unsatisfied deductible. After you have satisfied the deductible, the insurance will cover the fees at ____ of their Usual and Customary Rate (UCR). You will be responsible for the remaining _____ co-insurance. Unfortunately, your insurance will not disclose to us the exact amount of what they will reimburse. According to your insurance carrier's disclaimer, this is not a guarantee of payment until the claim is received and reviewed for payment based on your eligibility and benefits at the time the claim processed. ANY/ALL remaining balance after the insurance makes their payment will be your responsibility.

The hospital and anesthesia claim will be sent directly and separately to your insurance company form the facility's billing department. If you have any questions or you want to verify the hospital and anesthesia coverage and participation, please call your insurance carrier. Also, if you want to get an estimate of the hospital and anesthesia charges, Please call the Surgical Center _____.

You are more than welcome to call your insurance company if you need further clarification about your benefits, coverage, and financial responsibility.

We will bill the insurance first for the surgeon's charges and thereafter send you a bill for your financial responsibility. Our system automatically generates a bill to you when we send the claim to your insurance company for the surgeon's charges. So, do not be alarmed when you receive a bill for the surgeon's charges billing you for the full amount. We will send you another bill after your insurance company sends us the payment. If you receive the payment from the insurance company, please endorse the check to the surgeon and mail it to: NY Orthopedics, Attn: Billing Dept., 130 E. 77th St. 5th Floor, New York, NY, 10075

Kindly call me back to confirm that we have the correct insurance information and acknowledge that you have received and understood what this letter entails. Should you have any further questions or concerns, please do not hesitate to contact me at the office. Thank you.

SMH9

Esther Sanchez
Surgical Coordinator

Patient Signature _____
Patient Name:
Date: