

Attachment to CR 102

DRAFT



Agreement to Pay for Healthcare Services

WAC 388-502-0160 ("Billing a Client")

This is an agreement between a "client" and a "provider," as defined below. The client agrees to pay the provider for healthcare service(s) for which the Department of Social and Health Services (DSHS) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, "services" include but are not limited to healthcare treatment, equipment, supplies, and medications.

1. **Client** - is a recipient of Medicaid or other healthcare benefits through the DSHS or a DSHS-contracted managed care organization (MCO); and
2. **Provider** - is an institution, agency, business, or person that has a signed agreement with DSHS or authorization from a DSHS-contracted MCO to furnish healthcare services to DSHS clients.

This Agreement and WAC 388-502-0160 apply to billing a client for covered and noncovered services as described in WAC 388-501-0050 through WAC 388-501-0070. Providers may not bill any DSHS client (including those enrolled with a DSHS-contracted MCO) for services which DSHS or a DSHS-contracted MCO may have paid until the provider has completed all requirements for obtaining authorization.

CLIENT'S PRINTED NAME	CLIENT'S DSHS ID NUMBER
PROVIDER'S PRINTED NAME	PROVIDER NUMBER

This form:

- Must be fully completed by both the provider and the client **before** any service for which this Agreement is required is provided to a DSHS client.
- Must be completed no more than 90 calendar days before the service is provided. If the service is not provided within 90 calendar days, a new form must be completed and signed by both the provider and the client.
- Must be completed only **after** the provider and the client have exhausted all applicable DSHS or DSHS-contracted MCO processes which are necessary to obtain authorization for the requested service(s). These may include the exception to rule (ETR) process for noncovered services as described in WAC 388-501-0160 or the administrative hearing process as described in WAC 388-526-2610, if the client chooses to pursue these processes.

Must be understandable to a limited English proficient (LEP) client in his or her primary language. This may include a translated form or interpretation of the form. If the form is interpreted for the client, the interpreter must also sign and date the form. A translated form must be signed by both the client and the provider.

The table on back of this form must be fully completed. If needed, attach another sheet for additional services. Each additional page must be signed and dated by the client, provider, and interpreter (if applicable).

Note to Provider from DSHS:

- This agreement is void and unenforceable if the provider fails to comply with the requirements of this form and WAC 388-502-0160 or does not satisfy DSHS conditions of payment as described in applicable Washington Administrative Code (WAC) and Billing Instructions. The provider must reimburse the client for the full amount paid by the client.
- See WAC 388-502-0160(9) for a list of services that cannot be billed to a client, regardless of a written agreement.
- Keep the original agreement in the client's medical record for 6 years from the date this agreement is signed. A copy of this completed, signed agreement must also be given to the client.
- Providers are responsible for ensuring that translation or interpretation of this form and its content is provided to LEP clients. Translated forms are available at <http://www.dshs.wa.gov/msa/forms/eforms.html>.

SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE	CPT/CDT/ HCPC CODE (BILLING CODE)	AMOUNT TO BE PAID BY CLIENT	REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)	COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT	DATE(S) ETR REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED	
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for		ETR REQUESTED OR WAIVED	ETR DENIAL (ATTACH DSHS NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for		PA REQUEST	PA DENIAL (ATTACH DSHS NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for		ETR REQUESTED OR WAIVED	ETR DENIAL (ATTACH DSHS NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for		PA REQUEST	PA DENIAL (ATTACH DSHS NOTICE)
<ul style="list-style-type: none"> • I understand that DSHS or a DSHS-contracted MCO does not cover the specific service(s) listed above, has denied the requested covered service(s) as not medically necessary for me, or does not pay for the specific type of covered service as indicated in the above table. • I understand that I can ask for an ETR after a DSHS denial of a request for a noncovered service or ask for a hearing to appeal a DSHS denial of a requested service, and that I may choose not to do so. • I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by DSHS or DSHS-contracted MCO, and I still choose to get the specified service(s) above. • I agree to pay the provider directly for the specific service(s) listed above. • I understand the purpose of this form and this provider answered all my questions to my satisfaction. This provider has given me a completed copy of this form. • I understand that I can call DSHS at 1-800-562-3022 if I want to receive additional information about my rights or services covered by DSHS under fee-for-service or managed care. 						
CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE					DATE	
I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 388-502-0160.			PROVIDER OF SERVICE(S) SIGNATURE		DATE	
I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above.			INTERPRETER'S PRINTED NAME AND SIGNATURE		DATE	