MUNSTER SPECIALTY SURGERY CENTER, LLC.

TO: Out of Network Members

RE: Non-participation provider

DATE OF SERVICE: _____

PATIENT: _____

Thank you for scheduling your procedure at MUNSTER SPECIALTY SURGERY CENTER, LLC.
Your physician designed this facility with you in mind, and recommends treatment here to provide you With the highest level of patient care. We are proud to serve you and are committed to meeting your healthcare needs in a state of the art environment, with a first rate staff and excellence in patient satisfaction.

Although MUNSTER SPECIALTY SURGERY CENTER LLC is not currently a participating provider with your Insurance Plan, we strive to give our patients the best possible value for their health care dollar, and we want to make it as simple as possible for you to manage the costs of services. While we cannot waive the patient responsibility required by your health plan, we are able to discount the cost of care. Our discount program allows us to provide access to superior quality to all patients in the community, regardless of insurance type, at a cost-effective rate for you, your family and your health plan.

Since we are unable to determine the exact amount your insurance will cover prior to your procedure, we request a deposit on your date of service, which will be applied to your total financial responsibility. Actual cost of care varies because the services we provide are individualized to best meet your needs. We will submit a claim to your insurance company on your behalf, and once the claim has been processed by your insurance carrier, we will send you a bill for any remaining balance, based on the amount allowed by your insurance company and your in-network benefits. Our pricing is competitive, and the total out of pocket expenses will be approximately the same, or less than what you would pay at another facility.

It is possible that the insurance payment for your visit will be sent directly to you. We ask that you please endorse the check over to the facility, and mail it, along with your Explanation of Benefits. Compliance with this request will allow us to process the payment to your account quickly and efficiently, and make any necessary adjustments.

If you have any questions or concerns, please do not hesitate to call our billing office at 877-265-8880 between the hours of 9:00 – 5:00 Mon-Fri.

We look forward to serving you, and appreciate being your preferred choice for surgical care.

_____ _____

Patient/patient representative **date**

_____ _____

Witness **date**

Patient Label