MONTGOMERY COUNTY HOSPITAL DISTRICT

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Montgomery County Hospital District (MCHD) is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. MCHD is required to notify an affected individual following a breach of unsecured PHI. MCHD is required to abide by the terms of the version of this notice currently in effect.

Uses and Disclosures of PHI: MCHD may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

For treatment: This includes such things as verbal and written information about your medical condition and treatment obtained from you, as well as from others provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For payment: This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For health care operations: This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

Reminders for Scheduled Transports and Information on Other Services: We may also contact you to provide you with a reminder of any scheduled appointments for non-emergency ambulance, medical transportation, vaccinations/clinic appointments, or to provide information about other services we provide.

Use and Disclosure of PHI without Your Authorization: MCHD is permitted to use PHI *without* your written authorization, or opportunity to object in certain situations, including:

- For treatment, payment for services provided to you or in other health care operations or for the treatment activities of another health care provider;
- Healthcare and legal compliance activities;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. In certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interest.
- To a public health authority in certain situations by law (such as reporting abuse or neglect or domestic violence);
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;

Effective Date of this Notice: March 28, 2016

HCAP Form A

- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- We may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals.
- We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Your authorization is required for: (l) Any use or disclosure of Psychotherapy notes, except as needed to carry out treatment, payment, or health care operations; or use by the originator of the psychotherapy notes for treatment; and (2) Marketing activities, except our face to face communications with you; and (3) Sale of PHI.

Any other use or disclosure of PHI not described in this notice will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Patient Rights: As a patient, you have a number of rights with respect to the protection of your PHI, including:

The right to access, copy or inspect your PHI: This means you may come to our offices and inspect and copy the PHI that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer under the contact information listed at the end of this Notice.

The Right to Confidential Communications: You have the right to receive confidential communications of your PHI.

The right to amend your PHI: You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct in pour records. If you wish to request that we amend the medical information that we have about you, you should contact the privacy officer under the contact information listed at the end of this Notice.

The right to request an accounting of our use and disclosure of your PHI: You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, like our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of PHI for which you have already given us written authorization. Your accounting will be provided without charge; however, MCHD may charge a reasonable fee for additional accounting requests made by the same individual during a 12 month period. If you wish to request an accounting, you should contact the privacy officer under the contact information listed at the end of this Notice.

MONTGOMERY COUNTY HOSPITAL DISTRICT

The right to request that we restrict the uses and disclosures of your PHI: You have the right to request that we restrict how we use and disclose your PHI that we have about you. Except in limited circumstances, MCHD is not required to agree to any restrictions you request, but any restrictions agreed to by MCHD are binding on MCHD. MCHD will restrict disclosure of PHI, when requested by an individual, if the disclosure is for the purpose of carrying out health care operations and the PHI pertains solely to a health care item or service for which the individual, or other person, has paid MCHD in full.

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request: If we maintain a web site, we will prominently post a copy of this Notice on our web site and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice: MCHD reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting the Privacy Officer identified below or at our website.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to the privacy officer listed at the end of this Notice.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Privacy Officer for MCHD
1400 South Loop 336 West
Conroe, Texas 77304
936-523-5016

Revision Date of this Notice: March 28, 2016

Montgomery County Hospital District
Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of Montgomery County Hospital District's Notice of Privacy Practices on this date.

_____ _____

Date/Fecha Signature/Firma

_____

Print Name of Client/Nombre En Letra De Molde

Effective Date of this Notice: March 28, 2016

HCAP Form A

MONTGOMERY COUNTY HOSPITAL DISTRICT

Health Care Assistance Program
1400 South Loop 336 West
Conroe, Texas 77304
Phone: 936-523-5100
Fax: 936-539-3450

Benefit Acknowledgement

HCAP#: _____

By initialing each section below, I prove that I have read, fully understand and acknowledge each item as it relates to my healthcare coverage on the Montgomery County Hospital District Health Care Assistance Program:

I understand that…

- ____ It is my responsibility to notify all my providers that I am on the Health Care Assistance Program (HCAP) by advising them to make a copy of my HCAP ID Card as it contains important information.
- ____ If I choose to visit a non-mandated provider, I will be responsible for the cost.
- ____ The program's in-network/mandated hospitals are **HCA Conroe, Kingwood, and Tomball and St. Luke's The Woodlands Hospital.** I understand that I must visit these hospitals in a non-emergent situation.
- ____ Montgomery County Hospital District's Emergency Medical Services (EMS) is the only mandated EMS service I may use and only in the case of an emergency.
- ____ Prime Dx, the third party administrator for the HCAP, is responsible for referrals to specialists. All services must be pre-authorized through Prime Dx; otherwise, I am responsible for any incurred charges. For preauthorization call: **800-477-4625.**
- ____ **HCAP covers only three (3) formulary prescriptions per month with a zero co-pay on both generic and brand prescriptions. All other medications will be at a discounted price.**
- ____ MCHD will only cover $60,000 for my health care services or the payment of 30 days of hospitalization or treatment in a skilled nursing facility, or both, whichever occurs first in a fiscal year (October to September). MCHD will only cover $20,000 of mental health counseling services in a fiscal year. I understand that anything which exceeds the limits set forth will be my responsibility.
- ____ **There is a 95-day filing deadline for all medical bills**. I am responsible for notifying my medical providers that I am on the health care assistance program. The medical provider needs to submit medical claims to the HCAP email address below. Claims not submitted within 95 days will become my responsibility for payment.

  Submit claims to: Claims@mchd-tx.org

- ____ I am requested to pay co-pays for my health care benefits. Co-pays are expected when visiting primary care, specialty care, emergency room visit, EMS transport and physical therapy. Co-pay's are based on my income and may range from $0 - $5.00 per the schedule listed below:

Copay Amounts						
	PCP	SCP	EMS	ER	Rx Generic	Rx Brand
MCICP	$0	$0	$0	$0	$0	$0
MAP	$5	$5	$5	$5	$0	$0

MONTGOMERY COUNTY HOSPITAL DISTRICT

Health Care Assistance Program
1400 South Loop 336 West
Conroe, Texas 77304
Phone: 936-523-5100
Fax: 936-539-3450

- ____ If I am involved in a motor vehicle accident (MVA) or an assault, this program will not pay for any medical expenses related to that accident or assault unless proper documentation is provided proving there is no other liability. I also understand that I must first *notify* the eligibility office within 14 days of this event and *provide* a police report and/or auto insurance information to the eligibility office as soon as possible.

- ____ On the application I signed it states, "I understand that by signing this application, I am giving MCHD the right to recover the cost of health care services provided by the MCHD from any third party. I agree to give MCHD any information it needs to identify and locate all sources of payment for health care services. I authorize any public or private agency to furnish MCHD or its agent information related to assets in my name and/or my criminal history, credit history, and employment history. I release MCHD, its employees and assigned agent and the agencies furnishing such information from liability resulting from the furnishing of this information to MCHD." I acknowledge that I have read, understand and agree to such statement.

- ____ It is my responsibility to reapply for HCAP benefits no earlier than 21 days before my card expires.

- ____ I understand the filing of an application form or receipt of HCAP health care services constitutes an assignment to Montgomery County Hospital District's Health Care Assistance Program of my right of recovery from (1) personal insurance; (2) other sources; or (3) another person for personal injury caused by the other person's negligence or wrong. Such assignment is limited to MCHD's costs expended on my behalf.

- ____ Since I have applied for health care assistance or will receive health care services, I agree to inform the Hospital District's Health Care Assistance Program, at the time of application or at any time during eligibility, of any unsettled tort claim that may affect medical needs and of any private accident or sickness insurance coverage that is or may become available. As an applicant, I agree to inform the District of any injury that is caused by the act or failure to act of some other person. As an applicant, I agree to inform the District immediately and in no event later than 14 days of the date in which I learn of any insurance coverage, tort claim, or potential cause of action.
    - A separate and distinct cause of action in favor of the District is hereby created, and the District may, without written consent, take direct civil action in any court of competent jurisdiction. A suit brought under need not be ancillary to or dependent on any other action.
    - The District's right of recovery is limited to the amount of the cost of services paid by the District.
    - As an applicant, if I knowingly and intentionally fail to disclose the information required by the District, I understand I will have committed a Class C misdemeanor.

- ____ As an applicant, I may be subject to denial of HCAP services following an appeals (administrative) hearing as set forth in the HCAP handbook.

- ____ I certify that the statements made by me on this form and on my application for health services are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I understand that any false statements made herein or on my application for health services from Montgomery County Hospital District will void further consideration for eligibility in Montgomery County Hospital District's Health Care Assistance Program as it relates to my application for such health services.

MONTGOMERY COUNTY HOSPITAL DISTRICT

Health Care Assistance Program
1400 South Loop 336 West
Conroe, Texas 77304
Phone: 936-523-5100
Fax: 936-539-3450

This benefit acknowledgement form has been explained to me and consent has been given of my own free will and bears my signature proving my understanding of all the information on this three-page document.

APPLICANT:

_____ _____
Signature Date

_____
Printed Name

MONTGOMERY COUNTY HOSPITAL DISTRICT
HEALTH CARE ASSISTANCE PROGRAM

BEHAVIORAL GUIDELINES

- All Applicants and Healthcare Assistance Program (HCAP) clients are required to comply with all Montgomery County Hospital District (MCHD) policies and guidelines to receive services through the Health Care Assistance Program.

- All Applicants or HCAP clients are required to comply with these behavioral guidelines established by MCHD. These guidelines apply to any contact the applicant or client may have with MCHD employees, our third party administrator, and any provider or affiliated provider in person, on the phone, or via written correspondence.

- All HCAP clients are expected to comply with the medical regimen proposed by their providers and case managers. Referred additional testing, such as lab, radiology procedures, or other specialist referrals, should be completed when scheduled as well. Our providers cannot properly treat without test results. HCAP clients will be terminated from the program for repeated non-compliance.

- No HCAP client shall receive any medications without periodic evaluation as required by the prescriber. HCAP clients will comply with the requirements of the Pharmacy Benefits Representative regarding drug utilization and patient assistance program applications.

- Clients will be terminated from the HCAP for illicit drug usage and continued alcohol abuse, if not currently and actively seeking or participating in a supervised rehab program.

- All HCAP clients are expected to give all MCHD personnel and affiliated physicians, Primary Care or Specialists, at least 24 hours advance notice of cancellation of an appointment, if the client is unable to keep the appointment. The client will be terminated from the HCAP for repeated failure to keep scheduled appointments.

- All Applicants or HCAP clients will not display rude or disruptive behavior and/or use abusive language. MCHD personnel and MCHD's affiliated parties will be protected from dangerous situations; physical or combative confrontations are grounds for immediate termination from the HCAP.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE GUIDELINES. I UNDERSTAND THAT A VIOLATION OF ANY OF THE ABOVE GUIDELINES MAY RESULT IN THE LOSS OF MY HCAP COVERAGE.

APPLICANT:

Signature: _____ Date: _____

Printed Name: _____

FRAUD POLICY & PROCEDURES

Montgomery County Hospital District (MCHD)
Healthcare Assistance Program (HCAP)

Montgomery County Hospital District has adopted the following as the Fraud Policy & Procedures for the Healthcare Assistance Program effective October 1, 2010.

Jeanette Whatley
MCHD Board Chair

Sept. 28, 2010
Date

General Provisions

I. Indication of fraud: program violation consists of intentionally, knowingly, or recklessly committing any of the following actions:
   a. Making a false and/or misleading statement
   b. Misrepresenting, concealing, or withholding facts
   c. Violating any provision of the CIHCP Act, the CIHCP regulation or State Statutes relating to the use or acquisition of benefits through MCHD HCAP.

II. Possible Misrepresentations - Situations are varied in which an applicant or recipient might intentionally withhold information or present false information to obtain assistance or benefits to which he/she is not entitled. Examples include, but may not be limited to:
   a. Information misrepresented or concealed at the time any of the MCHD HCAP forms are completed;
   b. Information misrepresented at the time legal requirements (HCAP Eligibility) are tested for initial certification or recertification;
   c. Information misrepresented concerning income or resources, composition of family group, county of residency, and some element of need;
   d. Information misrepresented to obtain prescribed drugs over the authorized limit;
   e. Information misrepresented or concealed concerning incapacity;
   f. Information misrepresented or concealed by a member of recipient's family, authorized representative, or any other individual(s) who assist recipient in obtaining medical services via HCAP;
   g. Use of fictitious names and/or sources of identification;
   h. Misrepresentation on guardianship or custody of children in household and/or status for adults in the household, including but not limited to military dependents status and alien sponsorship;
   i. Failure to report changes in income, resources, hospital district residency status, citizenship status, and/or household composition within 14 days of receipt as agreed upon as condition of HCAP enrollment.

Procedure

When the Healthcare Assistance Program (HCAP) staff has reason to believe that fraud may have occurred; the following procedures shall be followed:

a. The HCAP staff shall investigate all cases of suspected fraud and shall collect and document evidence;

b. The HCAP staff shall contact the client who is suspected of fraud by sending a certified letter informing him/her of the proposed withdrawal of eligibility and explaining the allegations and giving the client ten days to provide information disputing the allegations. If the client disputes the allegations, the client will be allowed to submit applicable supporting document/verification for further consideration;

c. If the client has disputed the allegations and presented his/her supporting information to HCAP staff, but the matter remains unresolved, the HCAP staff shall schedule an administrative hearing to allow the client to defend him/herself by confronting any adverse witness and by presenting his own argument and evidence. The HCAP staff must disclose any evidence used to prove its case to the client so he/she has an opportunity to dispute it. The Manager of the HCAP Department, with the Eligibility Supervisor present will conduct the administrative hearing. The hearing shall be held at the HCAP offices during normal business hours. The client shall be given thirty days written notice of the date of the hearing. If the client does not appear at the administrative hearing the Eligibility Supervisor may proceed with presentation of his/her case only if proof of notice is present. The HCAP Manager must make a decision within thirty days of the hearing.

Consequences of Fraud

If, after due process, a person is found to have intentionally misrepresented information in order to receive benefits, that person may be subject to prosecution under the Texas Penal code in addition to being deemed administratively ineligible for HCAP.

Upon a finding of fraud, the client shall be administratively ineligible from HCAP benefits as follows:

1. First offense of fraud determined:

   a) Client must make full restitution to MCHD HCAP; or
   b) The following penalty timeframe table will be followed to determine the administrative ineligibility

Amount Paid In Healthcare Expenses while Ineligible for Benefits	Denial Period
$ .01 to $ 249.99	1 month
$ 250.00 to $ 999.99	3 months
$1,000.00 to $2,999.99	6 months
$3,000.00 to $4,999.99	9 months
$5,000.00 or greater	12 months

c) **Penalty Exception:** If amount owed to MCHD is equal to or less than $500, the client may have benefits reinstated for 3 months from date of determination of fraud if an agreement is signed that full restitution will be made within the three month period.
   i. This exception only applies for client's first offense of fraudulent behavior.
   ii. If full restitution is not made within that timeframe, then client will be administratively ineligible for timeframe established by penalty timeframe table starting from restitution deadline or until full restitution is made, whichever condition is met first.

2. Second Offense of fraud determined:
   a) Client must make full restitution to MCHD before being allowed reenrollment into HCAP; or
   b) Client must serve penalty timeframe; and
   c) Client must serve an additional 3 month penalty.

3. Third or more offense of fraud determined:
   a) Client must make full restitution to MCHD before being allowed reenrollment into HCAP; or
   b) Client must serve full penalty timeframe; and
   c) Client must serve an additional 6 month penalty added to penalty timeframe; and
   d) Client must be granted permission to re-enroll in HCAP by MCHD Executive Officers.

I hereby acknowledge, I have read and understand the above information stated in this document.

_____ _____

HCAP CLIENT SIGNATURE DATE

MONTGOMERY COUNTY HOSPITAL DISTRICT

Health Care Assistance Program
1400 South Loop 336 West
Conroe, Texas 77304
Phone: 936-523-5100
Fax: 936-539-3450

This form is required to be completed by applicant

Medical History Form

HCAP #: _____

Name: _____ Date of Birth: ____/____/____ Date: ____/____/____

What is your primary medical concern?

_____

_____

Do you have any unpaid medical bills/hospitalizations within the past 95 days? ☐ Yes ☐ No

If yes, please complete the following information:

Facility/Hospital	**Admit Date**	**Discharge Date**

State reason for visit

Please list doctors/physicians/psychiatrist/psychologists that you are currently seeing:

Doctor's Name	Reason for doctor visit	Specialty

Please list all medications you are currently taking (*please use the back of this form for more space or provide separate copy of your updated list)*.

Medication	Reason for Medication	Daily Dosage

Please List any Allergies:

_____

_____

MONTGOMERY COUNTY HOSPITAL DISTRICT

Health Care Assistance Program
1400 South Loop 336 West
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This form is required to be completed by applicant

Please indicate if you have injuries related to the list below. If yes, please specify:

Work ❑Yes ❑ No _____

Motor vehicle accident (MVA) ❑ Yes ❑ No _____

Assault ❑ Yes ❑ No _____

Medical Problems/ Disease/ Diagnosis

Please indicate whether you have had or have been diagnosed with or are under active treatment for any of the following medical problems

- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Bipolar Disorder
- ❑ Blood Clots
- ❑ Cancer
  Type _____
- ❑ Cardiac Arrhythmia
- ❑ Cataracts
- ❑ Chest Pain
- ❑ COPD/Emphysema
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ Gallbladder Disease
- ❑ Glaucoma
- ❑ Heartburn/Gastric Reflux
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Heart Valve Disorder
- ❑ Headaches/Migraines
- ❑ Hepatitis/Liver Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Irritable Bowel Syndrome
- ❑ Kidney Disease
- ❑ Osteoporosis
- ❑ Schizophrenia
- ❑ Seizure Disorder
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Other

_____ _____

Client Signature **Date**

MONTGOMERY COUNTY HOSPITAL DISTRICT

Health Care Assistance Program
1400 South Loop 336 West
Conroe, Texas 77304
Phone: 936-523-5100
Fax: 936-539-3450

RELEASE FORM

HCAP#: _____

This release form has been explained to me and consent has been given of my own free will and bears my signature proving my understanding of all the information on this four-page document.

I _____ request that information be released to Montgomery County Hospital District's Health Care Assistance Program.

I consent to the release of any of my confidential, personal medical record or other medical, employment, criminal, credit, or financial information, which may be necessary to assist in the processing of my application for HCAP benefits or in providing medical services.

I hereby release MCHD and all of its agents and employees, the public agencies providing such information and all employees of public agencies or other entities furnishing information, from all liability resulting from the furnishing of this information to MCHD.

In addition, I hereby consent to the use and production by MCHD, of photos made, for any purpose without compensation to me. All cards including photos shall constitute MCHD property, solely and completely.

APPLICANT:

_____ _____
Signature Date

_____
Printed Name

Montgomery County Hospital District

Health Care Assistance Program (HCAP)

Bill Pay-Client Responsibility Form

___ It is my responsibility to contact all medical providers immediately and notify them of my HCAP coverage. Claims not submitted within **95 days** will become my responsibility for payment.

___ I am responsible for instructing all medical providers where to submit medical claims, as indicated on my HCAP card. **I understand that I cannot send medical bills to the HCAP office, and that only medical providers must do this.**

___ In the event of receiving a medical bill, it is my responsibility to contact the medical provider and instruct their staff to submit medical claims to the HCAP office as indicated on my HCAP card.

___ I understand that medical claims received by HCAP will be processed adhering to District and State procedures and guidelines.

___ I understand that HCAP is not responsible for any action a medical provider might take prior to, or following, the processing of claims by the HCAP office. This includes **balance billing, incorrect billing, rebilling, billing errors, refusal to see client, etc.**

Client Signature **Date**

Montgomery County Hospital District

Health Care Assistance Program (HCAP)

Bill Pay-Formulario de Responsabilidad del Cliente

___ Es mi responsabilidad contactar a todos los proveedores médicos inmediatamente y notificarles sobre mi cobertura con HCAP. Facturas que no sean recibidas dentro de **95 días** se convertirán en mi responsabilidad de pago.

___ Soy responsable de indicar a todos los proveedores médicos hacia dónde enviar facturas médicas, tal cual como se indica en mi tarjeta HCAP. **Entiendo que no puedo enviar facturas médicas a la oficina de HCAP, y que solo proveedores médicos pueden hacer esto.**

____ En caso de recibir una factura médica, es mi responsabilidad contactar a dicho proveedor médico e indicarle a su equipo que las facturas médicas deben ser enviadas a la oficina de HCAP, tal cual como se indica en mi tarjeta HCAP.

___ Entiendo que las facturas médicas recibidas por HCAP serán procesadas siguiendo procedimientos y pautas tanto del Distrito como del Estado.

___ Entiendo que HCAP no es responsable de cualquier acción que un proveedor médico pueda tomar antes, o después, del procesamiento de facturas por parte de la oficina de HCAP. Esto incluye **facturación de saldo, facturación incorrecta, facturación múltiple, errores de facturación, rehusarse a prestar servicios, etc.**

Firma del Cliente **Fecha**