Self-Pay Agreement

EVERNORTH℠

Self-Pay Agreement

I, ______________________________, have been notified by my
Participant Name

____
Practitioner Name

and/or a Evernorth Behavioral Health representative ______________________________ that my treatment is
Evernorth Behavioral Health Representative Name

not a covered benefit under my benefit plan or that my treatment starting at __________ is no longer covered by my benefit
Date

plan because Evernorth Behavioral Health had determined the treatment does not meet standards for medical necessity. **I am aware of Evernorth Behavioral Health's formal clinical appeal process and have elected not to appeal this decision at this time.** Instead, I have chosen to continue treatment with my provider/facility on a self-pay basis starting __________, which is
Date

no earlier than signature date.

I understand that it is my responsibility to pay ______________ for
Amount

____
Services

and I will not be reimbursed by Evernorth Behavioral on a later appeal.

I have been informed that I have the right to request an appeal at a later date.

This Self-Pay Agreement applies only to the service listed above. If I move to another level of care, an authorization from Evernorth Behavioral Health must be obtained or another Self-Pay Agreement signed.

______________________________ __________
Signature of Participant **Date**

______________________________ __________
Witness **Date**

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