



Client Acknowledgment Statement Form

I understand my doctor, _____, or Amerigroup has said the services
Provider name
or items I have asked for on _____ are not covered under my
Dates of service

Amerigroup plan. Amerigroup will not pay for these services. Amerigroup has set up the administrative rules and medical necessity standards for the services or items I get. I may have to pay for them if Amerigroup decides they are not medically necessary or are not a covered benefit, and if I sign an agreement with my provider prior to the service being rendered that I understand I am liable for payment.

Date: _____
Member name (print)

Member signature

Participating providers may bill a member for a service that has been denied as not medically necessary or not a covered benefit **only if the following conditions are true:**

- The member requests the specific service or item
- The member was notified by the provider of the financial liability in advance of the service
- The provider obtains and keeps a written acknowledgment statement signed by the provider and by the member, above, prior to the service being rendered

Date: _____
Provider name (print)

Provider signature