

Surprise/Balance Billing Disclosure Form
Cheyenne Eye Clinic & Surgery Center
1300 E 20th St Cheyenne WY 82001 (307)-635-2020

Your Rights and Protections Against Surprise Medical Bills

When you receive emergency care or get treated by an out-of-network provider at an in-network clinic or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network clinic or ambulatory surgical center

When you get services from an in-network clinic or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, and assistant surgeon. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

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Non-emergency Services at an In-Network or Out-of-Network Facility

Facility or agency staff must tell you if you are at an out-of-network location or if they are using out-of-network providers when known. Staff must also tell you what types of services you will be receiving that might be provided by an out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is unavailable. If your insurer covers the service, you can only be billed for your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- The provider or facility or agency must refund any amount you overpay within 60 days of being notified.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact 800-985-3059 regarding federal regulations, or the facility's billing department at 307-773-7150.

Visit [cms.gov/nosurprises/consumers](https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

My signature acknowledges receiving this notice and does not waive my rights under the law.

Name of patient (printed)	Relationship to patient	
Signature of patient or legally authorized representative	Date	Time
Interpretation: Discussion interpreted for patient/representative by (name or #) if applicable _____		