

## Agreement to Pay for Healthcare Services

WAC 182-502-0160 ("Billing a Client")

This is an agreement between a "client" and a "provider," as defined below. The client agrees to pay the provider for healthcare service(s) that the Health Care Authority (HCA) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, "services" include but are not limited to healthcare treatment, equipment, supplies, and medications.

**Client** - A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.

**Provider** - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

This Agreement and WAC 182-502-0160 apply to billing a client for covered and noncovered services as described in WAC 182-501-0050 through WAC 182-501-0070. Providers may not bill any HCA client (including those enrolled with an MCO that contracts with the HCA) for services which the HCA or an MCO that contracts with the HCA may have paid until the provider has completed all requirements for obtaining authorization.

CLIENT'S PRINTED NAME	CLIENT'S ID NUMBER
PROVIDER'S PRINTED NAME	PROVIDER NUMBER

### Directions:

- Both the provider and the client must fully complete this form **before** an HCA client receives any service for which this Agreement is required.
- You must complete this form no more than 90 calendar days before the date of the service. If the service is not provided within 90 calendar days, the provider and client must complete and sign a new form.
- The provider and the client must complete this form only **after** they exhaust all applicable HCA or HCA contracted MCO processes which are necessary to obtain authorization for the requested service(s). These may include the exception to rule (ETR) process for noncovered services as described in WAC 182-501-0160 or the administrative hearing process, if the client chooses to pursue these processes.
- Limited English proficient (LEP) clients must be able to understand this form in their primary language. This may include a translated form or interpretation of the form. If the form is interpreted for the client, the interpreter must also sign and date the form. Both the client and the provider must sign a translated form.

**Fully complete the table on back of this form. If needed, attach another sheet for additional services. The client, provider, and interpreter (if applicable) must sign and date each additional page.**

### Important Note from HCA:

- This agreement is void and unenforceable if the provider fails to comply with the requirements of this form and WAC 182-502-0160 or does not satisfy HCA conditions of payment as described in applicable Washington Administrative Code (WAC) and Billing Instructions. The provider must reimburse the client for the full amount paid by the client.
- See WAC 182-502-0160(9) for a list of services that cannot be billed to a client, regardless of a written agreement.
- Keep the original agreement in the client's medical record for 6 years from the date this agreement is signed. Give a copy of this completed, signed agreement to the client.
- Providers are responsible for ensuring that translation or interpretation of this form and its content is provided to LEP clients. Translated forms are available at <http://hrsa.dshs.wa.gov/mpforms.shtml>.

SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE	CPT/CDT/ HCPC CODE (BILLING CODE)	AMOUNT TO BE PAID BY CLIENT	REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)	COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT	DATE(S) ETR/NFJ REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED, IF APPLICABLE
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED ETR DENIAL (ATTACH HCA NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED ETR DENIAL (ATTACH HCA NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED ETR DENIAL (ATTACH HCA NOTICE)
<ul style="list-style-type: none"> <li>I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table:                          1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not.</li> <li>I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service; 2) submit a Non-Formulary Justification (NFJ) with the help of my prescriber for a non-formulary medication; or 3) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service.</li> <li>I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the specified service(s) above.</li> <li>I understand that HCA does not cover services ordered by, prescribed by, or are a result of a referral from a healthcare provider who is not contracted with HCA as described in Chapter 182-502 WAC.</li> <li><i>I agree to pay the provider directly for the specific service(s) listed above.</i></li> <li>I understand the purpose of this form is to allow me to pay for and receive service(s) for which HCA or an HCA-contracted MCO will not pay. This provider answered all my questions to my satisfaction and has given me a completed copy of this form.</li> <li>I understand that I can call HCA at 1-800-562-3022 to receive additional information about my rights or services covered by HCA under fee-for-service or managed care.</li> </ul>					
IAFFIRM: I understand and agree with this form's content, including the bullet points above.			CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE		DATE
IAFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160.			PROVIDER OF SERVICE(S) SIGNATURE		DATE
IAFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above.			INTERPRETER'S PRINTED NAME AND SIGNATURE		DATE