Appendix I, Member Acknowledgement Statement

I understand that, in the opinion of [Provider Name], the services or items that I have requested to be provided to me on [Date(s)] may not be covered under the Medicare-Medicaid program as being reasonable and medically necessary for my care. I understand that the Illinois Department of Healthcare and Family Services (HFS) or its health-insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

Patient Signature: _____

Date: _____