Notwithstanding this authorization, failure to comply with the established terms and conditions with our organization or its policies and procedures will result in a claims denial. All claims related to this authorization must be prior authorized. Failure to coordinate with our organization (e.g. discharge planning) may result in claims denial. All further claims must be prior-authorized. Failure to seek prior authorization may result in claims denial.

Please note that all financial information to satisfy Mental Health Code Chapter 8 Financial Liability for Mental Health Services must be satisfied in order for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hereinafter known as "Payor") to render payment. All claims for payment must be submitted within 60 days of treatment unless third party reimbursement is pending.

**Coordination of Benefits**: The Provider, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledges that the Payor, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, shall be the payer of last resort for Payor-authorized services under this Agreement subject to the terms and conditions herein. For consumers or potential consumers Provider staff shall complete an initial determination and periodic re-determinations of financial status. Provider shall be responsible for establishing the eligibility for third party reimbursement status, including Medicaid, and Supplemental Security Income benefit status. Provider staff will assist Payor staff, when possible, in securing and maintaining such benefit status of the consumer. Provider staff shall make pertinent sections of recipient program records available to appropriate Payor staff as required to meet the obligations contained herein. Payor shall be responsible for seeking services reimbursements, if applicable from third party liability claims for the consumer, pursuant to federal and state requirements.

The Payor shall not assume reimbursement responsibility for any Consumer hereunder without documented evidence that Provider has sought Medicaid eligibility, Medicare or other benefits, as indicated, for such Consumer. Further, Payor shall not assume reimbursement responsibility if benefits are denied due to the Provider failure to provide thorough assistance to a Consumer in making an application to obtain any and all available benefits. If Payor determines that such a denial was due to incomplete or inaccurate application information, then the Provider shall formally reapply and otherwise appeal said denial of Medicaid, Medicare, or other benefits. Provider shall not be reimbursed or otherwise compensated by the Payor for any loss of Medicaid, Medicare, or other reimbursement(s) resulting from such a failure of Provider staff. Payor payments to Provider shall be contingent upon receipt of accurate billings of valid claims which indicate Payor Consumer(s) serviced, benefit status, and the services provided.

If you have any questions, please feel free to contact me at \_\_\_\_\_\_\_\_\_\_

Respectfully,

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