

111 Colchester Avenue  
Burlington, VT 05401

MRN \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Notice of Financial Responsibility to Medicaid Beneficiaries**

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VT Medicaid Provider # 0470003

NY Medicaid Provider # 00353851

Patient Name: \_\_\_\_\_

MRN: \_\_\_\_\_

Item or Service(s) being sought: \_\_\_\_\_

CPT/HCPCS (if applicable): \_\_\_\_\_

Estimated Cost: \$ \_\_\_\_\_

The University of Vermont Medical Center is unwilling to bill or accept Medicaid payment for the above listed item(s) or service(s) because the service is not considered a covered Medicaid benefit. If you wish The University of Vermont Medical Center to provide the item or service you must accept full financial responsibility.

I understand and agree to be personally financially responsible for the item(s)/service(s) listed above and that I will be billed directly by The University of Vermont Medical Center. I also understand that The University of Vermont Medical Center will not bill Medicaid the item(s)/service(s).

Signature of beneficiary or legal representative: \_\_\_\_\_  
(If legal representative, please note relationship.)

Date/Time: \_\_\_\_\_

Witness: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Make three copies of signed document and distribute as follows:

1) patient's copy, 2) scan a copy into Epic and 3) attach a copy for billing, if applicable

