MEMBER / CLIENT ACKNOWLEDMENT STATEMENT

SAMPLE

"I understand that, in the opinion of ____________________ , the
(Provider Name)

services or items that I have requested to be provided to me on the

______________________ may not be covered under the Community
(dates of service)

First CHIP Perinate Program as being reasonable and medically necessary

for my care. I understand that I am responsible for payment of the

services or items I requested and receive if these services or items are

determined not to be reasonable and medically necessary for my

care."