



## Member/Client Acknowledgement Statement

A Provider may not bill a Community First Medicaid Member for covered services, which Community First determines are not medically necessary, unless you obtain the Member's prior, written, informed consent.

**A Provider may bill the Community First Medicaid Member for a service if both of the following conditions are met:**

- The patient requests the specific service.
- The Provider obtains a "Member/Client Acknowledgment Statement" signed by the patient and the Provider.

I understand that, in the opinion of, *(Provider Name)* \_\_\_\_\_, the services or items that I have requested to be provided to me may not be covered under the Community First Health Plans Medicaid 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.

Member/Client Signature: \_\_\_\_\_

Member/Client Printed: \_\_\_\_\_

Date: \_\_\_\_\_

Community First Member ID Number: \_\_\_\_\_