Request for Restriction Not to Bill Health Plan or Insurance

Individual to complete the following: (please print)

Name: ___________________________ Last  First  Middle

Address: _____________________________________________________________

Telephone: __________________ Date of birth: _________________________

Medical Record No: __________________________________________________

Request:
You have the right to request Pacific University not disclose information about your treatment to your health plan for purposes of payment. If you do not want Pacific University to disclose your health information to your health plan for a specific item/visit, Pacific University must be notified prior to the time of service and paid in full.

Description of health care item or service:

____________________________________________________________________________
____________________________________________________________________________

Health plan/insurance: __________________________ Date of service: ______________

Amount paid in full: __________________________ Date paid: ______________

By submitting this form, I hereby request Pacific University not submit my health information to my health plan for the above specified item or service.

Signature: ___________________________________________ Date: _____________

(If signature is by a personal representative, please print the following):

Personal representative’s name: _____________________________________________

Relationship to Patient: __________________________________________________

Mail this form to: Pacific University
Privacy Officer
2043 College Way #A-118
Forest Grove, OR 97116

Approved:
Reviewed:
Revised: 10/2017