|  |  |
| --- | --- |
| Text  Description automatically generated | Patient responsibilityPatient Responsibility Checklist |

| Done? | Item | Items Needed to Complete | Who is responsible | Date of 1st attempt | Date of 2nd Attempt |
| --- | --- | --- | --- | --- | --- |
|[ ]  Current demographic sheet | Demographic Sheet completed by family for 2021 |  |  |  |
|[ ]  Copy of front and back of insurance card (Primary & Secondary) | Copy of front/back of insurance card |  |  |  |
|[ ]  Updated financial responsibility signed | Financial Responsibility form  |  |  |  |
|[ ]  Cost analysis form reviewed with family | Patient’s cost share reviewed with family with approximate estimate of monthly cost |  |  |  |
|[ ]  Verify the cost share is in line with the expected In or Out of Network benefits that have been previously reviewed with the family. | Review of the total amount billed to family as compared to the Verification of Benefits previously performed. |  |  |  |
|[ ]  Apply patient responsibility once benefits have been verified and there is not secondary insurance. | Submit statements to family. |  |  |  |
|[ ]   |  |  |  |  |