

EASTERN VIRGINIA MEDICAL SCHOOL
DIVISION OF MATERNAL-FETAL MEDICINE
DIVISION OF GENERAL OBSTETRICS & GYNECOLOGY
DIVISION OF UROGYNECOLOGY

PENDING INSURANCE LETTER OF UNDERSTANDING

As an uninsured patient I, _____, agree to abide by the payment plan as stipulated by the Division of Maternal-Fetal Medicine, Eastern Virginia Medical School.

- I have applied for Medicaid and understand I am required to show proof of my application. If I should be denied for Medicaid, I understand that I am responsible for any charges incurred.

- I have not applied for Medicaid, however I plan on applying within _____ days. I understand that I am required to show proof of my application upon my next appointment. If I should be denied, I understand that I am responsible for any charges incurred.

Beginning 30 days from the date of your Medicaid application, if you have not been approved for Medicaid, payment arrangements must be made for any charges incurred.

Date

Responsible Party Signature

Date

EVMS Witness