MARION SURGERY CENTER LLC

Date: _____

To: Out of Network Members

Re: Non-Participating Provider Agreement

Patient: _____

Account: _____

It is the intention of Marion Surgery Center, LLC dba Marion Surgery Center to extend "**in-network benefits"** to all of our patients. Your insurance company will pay the surgery center as a non-participating provider and it is our intention to honor their payment without additional cost to you than if we were a participating or "in-network" provider. It is possible that your insurance payment for your visit to Marion Surgery Center, LLC will be sent directly to you. **In the event payment is sent directly to you, please endorse the check over to the center, and mail the check along with the Explanation of Benefits you will receive from your insurance provider.** By sending such payment you receive directly to the center you avoid the possibility of additional costs for using our facility. Compliance with this request will allow us to process the payment to your account quickly and efficiently, and to make any necessary adjustments without the need to bill you for services due to non-payment.

_____ _____

Patient/Responsible Party Date

_____ _____

Witness Date

2207 SW 1st Avenue Ocala, FL 34471
Phone: (352)732-4020 Fax: (352)732-4042