



**OREGON HEALTH PLAN  
PATIENT RESPONSIBILITY WAIVER**

The following services are not covered benefits under the Oregon Health Plan:

\_\_\_\_\_  
Medical, Dental and/or surgical services

\_\_\_\_\_  
Condition/Diagnosis

I, \_\_\_\_\_  
(Patient Name and OHP Identification Number)

understand that the services listed above, for the condition listed above, are not covered for payment by \_\_\_\_\_ (Plan Name) or the Division of Medical Assistance Programs under the Oregon Health Plan. If I, or my dependant chooses to obtain the services listed above on this date, I agree to be personally responsible for paying the financial charges for these services. The estimated amount that I may be responsible for is \$ \_\_\_\_\_, and not to exceed \_\_\_\_\_.

\_\_\_\_\_  
PATIENT OR RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

\* If you have Medicare, you may have additional appeal rights. Contact:  
\_\_\_\_\_(Plan Name) Customer Services at  
\_\_\_\_\_(Phone Number) for further information.