



Request Not to Bill Health Plan or Insurance

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

Patient Name:
(Last) _____ (First) _____ (M.I.) _____

Address: (Street) _____ (City) _____ (State) _____

(Zip Code) _____

Telephone:
(day) (____) _____ (eve) (____) _____

Medical Record #: _____ Date of Birth _____

Description of the health care item or service:

Health Plan/ Insurance: _____

Amount paid in full: _____ Date paid: _____

Date of service: _____

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

Signature of Patient or Representative Date

Date form received

Salem Health Privacy Officer
890 Oak St SE
Salem, OR 97301