COVID-19 Uninsured Program Attestation

Patient Name: ______________________________ **Date:** ____________________

Date of Birth: ________/______/____________ **SSN:** _______-______-_______

As part of the FFCRA, Paycheck Protection Program and Health Care Enhancement Act, and CARES Act, the U.S. Department of Health and Human Services (HHS) will provide claims reimbursement to health care providers for testing uninsured individuals for COVID-19 and treating uninsured individuals with a COVID-19 diagnosis.

I attest that:

- **I am uninsured.**
- **I do NOT have health care coverage (individual, employer-sponsored, Medicare, or Medicaid).**
- **No other payer will reimburse for COVID-19 testing and/or treatment/care.**
- **My visit today is for COVID-19 symptoms, known exposure or suspected exposure. Any charges incurred that are not covered by this program are my financial responsibility.**
- **If I enroll in any insurance plan, whether commercial, Medicaid or Medicare and the effective date is backdated to cover this particular visit, I agree to notify AFC of such coverage.**

I authorize AFC Urgent Care (Jersey Irish Medical) (the P.C.) to keep my credit or debit card on file and to charge my card for amounts determined by HRSA/Medicare to be my responsibility, or if my claim is denied, all amounts that AFC Urgent Care (the P.C.) is authorized by law to bill me. I assign my insurance benefits to the provider listed above. I understand this agreement is valid for one year and will automatically renew annually unless this authorization is cancelled through written notice to AFC Urgent Care (the P.C).

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Patient Signature **Date**