COMMUNITY FIRST
HEALTH PLANS

Member/Client Acknowledgement Statement

I understand that, in the opinion of, Provider Name_____, the services or items that I have requested to be provided to me may not be covered under the Community First Health Plans' STAR Kids Medicaid Program as being reasonable and medically necessary for my care. I understand that I am responsible for payment of the services or items I requested and receive if these services or items are determined not to be reasonable and medically necessary for my care.

_____
Member/Client Signature

_____
Date