

Form for BCBSAZ Member to Waive the Protections Against Billing for Services Deemed Investigational or Not Medically Necessary



An Independent Licensee of the Blue Cross and Blue Shield Association

Patient Name	Member ID
Ordering Provider Name and NPI	
Name of Provider(s) Rendering Services	

Your provider has recommended that you receive the following medical services or items:

Services/Items	Estimated Costs
Services/Items	Estimated Costs
Additional Information	

We, _____ (*name of provider rendering services*), will submit a claim to BCBSAZ, but expect that BCBSAZ will not pay for these services/items because BCBSAZ will determine that the services are either:

- Not medically necessary benefits under your health plan
- Investigational under current evidence-based criteria

The fact that BCBSAZ might not pay for a particular service or item does not mean that you should not receive it. Please feel free to ask us to explain why BCBSAZ might decide that the services or items are not medically necessary or are investigational, and why we recommend that you receive the services/items.

Because _____ (*name of provider rendering services*) is contracted with BCBSAZ, if the claim is denied for the reasons listed above, we are not allowed to bill you for the service unless you agree to pay us. The purpose of this form is to help you make an informed choice about whether you want to receive these services/items, knowing in advance that you might have to pay for them yourself.

Choose **one** option, check **one** box, and then **sign** and **date**.

YES. I want to receive these items or services. I understand that:

- ✓ BCBSAZ will not decide whether to pay unless I receive these items or services and my provider submits a claim to BCBSAZ.
- ✓ BCBSAZ will decide whether to pay based on the claim my provider submits, any supporting medical records, the terms of my benefit plan, and current evidence-based criteria.
- ✓ If BCBSAZ denies the claim as not medically necessary or investigational, I will have to pay for these services myself, and I agree to be personally and fully responsible for payment.
- ✓ If BCBSAZ does pay the claim, you will refund to me any advance payments I made to you that are due to me.
- ✓ I can appeal BCBSAZ's decision to deny payment of the claim.

NO. I have decided that I do not wish to pay for these services/items if they are not medically necessary or considered investigational under my benefit plan. I understand that my provider may choose not to provide these services because I have not agreed to pay.

Signature of patient or person acting on patient's behalf

Date