



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

Patient's Name _____ BCBSAZ ID# _____

Ordering Provider Name and ID # _____

Name of Provider(s) Rendering Services _____

Your provider has recommended that you receive the following medical service(s) / item(s)

Services/Items	Estimated Costs
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Services/Items	Estimated Costs
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We (_____), (*name of provider rendering services*) expect that BCBSAZ will not pay for these service(s) / item(s) because BCBSAZ will determine that the services are:

- Not medically necessary benefits under your insurance plan; or
- Investigational under BCBSAZ medical policy guidelines.

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

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. The purpose of this form is to help you make an informed choice about whether you want to receive these service(s) / item(s), knowing that you might have to pay for them yourself.

CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **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 BCBSAZ medical policy guidelines.
- 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 items or services if they are either not medically necessary or are 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