Advance Member Notice

You need to make a choice about receiving these healthcare items or services

Patient Name:	Patient Health Plan ID:	Patient Date of Birth:
Provider Name:	Provider NPI Number:	Provider Phone: Provider Fax:

We expect that Blue Cross and Blue Shield of Montana (BCBSMT) will not pay for the item(s) or service(s) that are described below. BCBSMT only pays for covered items and services when BCBSMT rules are met. The fact that BCBSMT may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. BCBSMT may not pay for:

Items/Services: ____

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Rationale: ____

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The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- If you do not understand, ask us to explain why BCBSMT probably will not pay.
- In case you have to pay for them yourself or through other insurance, ask us how much these items or services will cost.

Estimated Cost = $______________________________

Choose one option and sign and date your choice

❑ **Option 1 - YES** I want to receive these items or services
I understand that BCBSMT will not decide whether to pay unless I receive these items or services. Please submit my claim to BCBSMT, and I understand that you may bill me for items or services, and that I may have to pay the bill while BCBSMT is making its decision. If BCBSMT does pay, you will refund to me any payments I made to you that are due to me. If BCBSMT denies payment, I agree to be personally and fully responsible for payment. I understand I can appeal BCBSMT's decision.

❑ **Option 2 - NO** I have decided not to receive these items or services
I will not receive these items or services. I understand that you will not be able to submit a claim to BCBSMT and that I will not be able to appeal your opinion that BCBSMT will not pay.

______________________ ____

Date **Signature of patient or person acting on the patient's behalf**

NOTE: **Your health information will be kept confidential by BCBSMT**. Any information that we collect about you on this form will be kept confidential. If a claim is submitted to BCBSMT, your health information on this form may be shared with BCBSMT.

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