Financial Responsibility for the Cost of Dental Services

If a BlueCross BlueShield of Tennessee DentalBlue Network Provider renders a service which is Investigational or does not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, **prior** to the service(s) being rendered, acknowledging that the Member understands he/she may be responsible for the cost of the specific service(s) and any related services. Providers may also utilize this form in the event a Member requests non-emergency, cosmetic or elective services that are specifically excluded under the Member's health benefits plan. It is essential the signed statement be kept on file, as it may be necessary to provide a copy of the signed statement to BlueCross BlueShield of Tennessee verifying the Member's agreement to the financial responsibility.

To help assist is this process, BlueCross BlueShield of Tennessee developed the *Acknowledgement of Financial Responsibility for the Cost of Dental Services* form for Provider use. This form meets the contractual obligations of BlueCross BlueShield of Tennessee DentalBlue Provider Agreements. **Providers are strongly encouraged to use this form**.

Providers using their own form should insure their form includes the following:

1. The name of the specific service/procedure the Provider will perform;
2. The reason why the Provider believes that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure; i.e., BlueCross BlueShield of Tennessee considers the service/procedure to be Investigational, Cosmetic or not Medically Necessary and Appropriate;
2. The approximate cost of the service/procedure and associated costs;
3. A statement acknowledging the Member understands that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure;
4. A statement acknowledging the Member has been advised why BlueCross BlueShield of Tennessee will not cover the service/procedure and that he/she understands and agrees that he/she will be responsible for all the costs and any associated costs;
5. A statement indicating the form is only valid for one (1) service/procedure; and
6. A specific expiration date.

A sample copy of the *Acknowledgement of Financial Responsibility for the Cost of Dental Services* form follows:

Financial Responsibility for the Cost of Dental Services

BlueCross BlueShield of Tennessee
Acknowledgement of Financial Responsibility
for the Cost of Dental Services
(For use with DentalBlue)

To: _____;

Re: (Identification of Prescribed Service)

I have been informed that my dental health care benefits insurer or administrator, BlueCross BlueShield of Tennessee, may determine that the above referenced dental service(s) may be an Investigational Service, Cosmetic, may not be a Covered Service or may not be Medically Necessary or Medically Appropriate as those terms are defined in my Member dental health care benefits plan from BlueCross BlueShield of Tennessee. Therefore, the dental service would be excluded from coverage by my dental health care benefits plan. My Dentist has also informed me about alternative treatments, if any, that may be covered by BlueCross BlueShield of Tennessee.

I understand that my Dentist may request that BlueCross BlueShield of Tennessee reconsider that determination by presenting evidence that the referenced dental service(s) is not an Investigational Service, is a Covered Service or the dental service is considered to be Medically Necessary or Medically Appropriate. I also understand that I have the right to request reconsideration of that determination, as described in the Member grievance section of my dental health care benefits plan, either before or after receiving the service(s).

I have been informed that the potential costs of the referenced dental service(s) will be approximately $_____. I understand that, if I elect to receive the dental service(s) and BlueCross BlueShield of Tennessee determines that the dental service(s) is an Investigational Service, is not a Covered Service or the service is not considered to be Medically Necessary or Medically Appropriate, I will be responsible to pay for all costs associated with the dental service(s), including, but not limited to, practitioner costs, facility costs, ancillary charges and any other related expenses. I acknowledge that BlueCross BlueShield of Tennessee may not pay for the dental service(s).

In the event of multiple dental procedures, this form is valid only for one (1) unit of the prescribed dental service(s), unless specifically provided for otherwise.

This form will expire and will no longer be valid six (6) months from the date of execution.

Signature of Patient or Responsible Person

_____

Date: _____