BlueCross BlueShield of Tennessee
Acknowledgement of Financial Responsibility
For the Cost of Services
(For use with Blue Networks C, S, P, K, and V)

To: _______________;

Re: (Identification of Prescribed Service)

I have been informed that my health care benefits insurer or administrator, BlueCross BlueShield of Tennessee, may determine that the above referenced 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 health care benefits plan from BlueCross BlueShield of Tennessee. Therefore, the service would be excluded from coverage by my health care benefits plan. My provider has also informed me about alternative treatments, if any, that may be covered by BlueCross BlueShield of Tennessee.

I understand that my provider may request that BlueCross BlueShield of Tennessee reconsider that determination by presenting evidence that the referenced service(s) is not an Investigational Service, is a Covered Service or the 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 health care benefits plan, either before or after receiving the service(s).

I have been informed that the potential costs of the referenced service(s) will be approximately $________________. I understand that, if I elect to receive the service(s) and BlueCross BlueShield of Tennessee determines that the 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 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 service(s).

In the event of multiple procedures, this form is valid only for one (1) unit of the prescribed 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

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Date: ________________________________