



**BlueCross BlueShield
of Tennessee**

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Out-of-Network Provider Election Form

BlueCross BlueShield of Tennessee member, _____
First Name Last Name

(_____) has elected to receive services at or from the following non-participating
ID #

hospital/provider (the "Provider"), _____ . Since this Provider is not
Hospital/Provider Name

participating in BlueCross BlueShield of Tennessee's networks, any benefits for Covered Services under the member's health benefits plan will be out-of-network benefits. By signing this document, the member understands that he or she could incur higher out-of-pocket Provider costs, including higher copayments, higher member coinsurance, and deductible. The member will also be responsible for charges billed by the Provider that exceed the Maximum Allowable Charge as defined by the member's health benefits plan.

In addition to the Provider charges, the member understands that providers at a hospital, such as radiologists, anesthesiologists, and others may also be out of network. Therefore, those provider's charges may be paid by the member's health benefits plan as out of network.

NOTHING IN THIS AGREEMENT IS A GUARANTEE OF BENEFITS UNDER THE MEMBER'S HEALTH BENEFITS PLAN. ALL BENEFITS WILL BE SUBJECT TO ALL TERMS AND CONDITIONS OF THE MEMBER'S HEALTH BENEFITS PLAN, INCLUDING ELIGIBILITY AND MEDICAL NECESSITY.

Doctor's Name (Print)

Member's Name (Print)

Doctor's Signature

Member's Signature

Date

Date

Member's Phone Number