of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

Date: _____

Acknowledgement of Financial Responsibility for the Cost of Services
(For use with BlueCross Commercial Networks)

Name of Provider: _____

Name of Patient: _____

Prescribed Service/Procedure: _____

I agree that I have been informed that my health care benefits insurer/administrator, BlueCross BlueShield of Tennessee, may not cover the above referenced service(s). I agree that my provider explained to me that BlueCross may not cover the referenced service(s) because the service is investigational, cosmetic or not medically necessary/appropriate. Additionally, my provider has also told me about alternative treatments available to me that may be covered by BlueCross.

I understand the potential costs of the service(s) above will be about $ _____ . I understand that if I choose to get the service(s) and it's not covered by BlueCross, I will be responsible for all costs associated with the service(s). This includes, but is not limited to, practitioner costs, facility costs, ancillary charges and any other related expenses. I accept that BlueCross may not pay for the service(s).

I understand my provider may ask BlueCross to reconsider their decision. I also understand I can request reconsideration of that decision, per the member grievance section of my health plan, either before or after receiving the service(s).

Finally, I understand that this form only applies to one procedure, unless otherwise specified. Also, this form is no longer valid as of six months from the date on this form.

Signature of Patient or Responsible Person

_____

Date: _____

* Please note provider must retain an executed copy of this statement on file as BlueCross BlueShield of Tennessee may request proof of documentation.

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