Empire BlueCross BlueShield

Waiver Form For:

- Non-Covered Services
- Not Medically Necessary Services
- Experimental/Investigational Services

I. Provider Information

Physician Name:_____

Practice Name:_____

Phone (___)_____

Provider EPIN/NPI:_____

II. Patient Information

Patient name: _____

Patient ID #:_____

DOB____/____/____ Sex : M ☐ F ☐

III. Wavier Form Statement & Provider Signature

The purpose of this waiver form is to inform Empire BlueCross BlueShield members, before they receive a medical service, that the service listed below is non-covered or not medically necessary or experimental/investigational. By signing this form, I, the physician acknowledge and agree that I have explained to the member that the service(s) listed are not a covered service(s).

_____ (Physician Signature)

_____ (Date)

IV. Reasons for Waiver Form

☐ **Non-Covered Service**

Benefits that may have been exceeded exhausted or excluded by Empire BlueCross BlueShield and, therefore, are the member's responsibility.

Patient Signature

I have been informed by the provider indicated in Section I. in advance that the service(s) listed below are services that are not covered under my member contract. I understand and agree that I am responsible for payment of the provider's charges for these services to the provider of service.

Patient Signature: _____

Date: _____

☐ **Not Medically Necessary Service**

☐ **Experimental/Investigational Service**

Not medically necessary and experimental/investigational services are not covered by Empire BlueCross BlueShield and, therefore, are the member's responsibility.

Patient Signature

I have been informed by the provider indicated in Section I. in advance that the service(s) listed below are not medically necessary or are services that are considered to be experimental or investigational and are not covered. I understand and agree that I am responsible for payment of the provider's charges for these services to the provider of service.

Patient Signature: _____

Date: _____

V. Service(s) To Be Provided

Date(s) of Service	Procedure/Service	Procedure Code*	Amount Charged
____/____/____			
____/____/____			
____/____/____			
____/____/____			

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.