Advance Member Notice

Completion of this form acknowledges that the member is fully responsible for all charges associated with the procedure/item/service requested below because the procedure/item/service may not be medically necessary and/or is not a covered benefit. This notice is not required for the member to receive medically appropriate and necessary covered services.

Procedure/Item/Service	CPT® / HCPCS Code	(Estimated) Billed Professional Charge

FOR THE PATIENT

I acknowledge that I am voluntarily signing this statement, and that it is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) for any procedure/item/service listed above that is denied as non-covered by Blue Cross Blue Shield of North Dakota and will pay the provider as charged. I also understand that it is my choice to have the services provided at a future date and time by this provider.

Patient Name _____

Benefit Plan Number _____

Patient Signature _____ Date _____

FOR THE PROVIDER

As a participating Blue Cross Blue Shield of North Dakota provider, I certify that I have informed the above patient regarding the Advance Member Notice. **I acknowledge that BCBSND medical policy, BCBSND Participation Agreement provisions, and any other policies promulgated by BCBSND, including any resulting decisions on financial responsibility, supersede this Advance Member Notice.**

Provider Name _____

Provider Signature _____ Date _____