Non-Covered Service Waiver Form

As a reminder, the provider must notify the member in writing at least two days before the date of the service that the service will not be covered.

This form must be signed on **each** date of service. Please retain this document in your patient's medical record.

For the Member

As a Blue Cross Blue Shield of Massachusetts member, I understand that I am responsible for all costs associated with the procedure/item listed below. My provider informed me before the date of service that Blue Cross Blue Shield of Massachusetts does not pay for this procedure/item because:

☐ The procedure or item is not considered medically necessary

☐ It is not a covered benefit under my plan

☐ He/she is not contracted to perform/provide this procedure/item

☐ Other: ______________________________

(to be completed by provider, if applicable)

Member name: ______________________________

Member ID (include alpha prefix): ______________________________

Member signature: ____________________ Date: ____________

We encourage you to call the Member Service number on your ID card to discuss non-covered services *before you receive the services*.

For the Provider

As a participating Blue Cross Blue Shield of Massachusetts provider, I certify that I have informed my patient, ____________________ that Blue Cross Blue Shield of Massachusetts does not allow payment for the procedure/item listed below because:

☐ The procedure or item is not considered medically necessary

☐ It is not a covered benefit under the member's plan

☐ I am not contracted to perform procedure or provide this item

☐ Other: ______________________________

Procedure/Item:	Procedure code:

Provider name: ______________________________

Provider signature: ____________________ Date: ____________