MASSACHUSETTS

NON-COVERED SERVICE WAIVER FORM

This form must be signed on <u>each</u> 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:	ESTIMATED COST:

Provider name: _____

Provider signature: _____ Date: _____