MASSACHUSETTS

NON-COVERED SERVICE WAIVER FORM

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

Note to providers: For Medicare Advantage members, a provider who believes a service may not be covered must request an authorization by using Authorization Manager or by calling our Medicare Advantage Clinical Intake team at **1-800-222-7620**. This waiver can be used only after the provider and member have received notice of the determination.

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
- ☐ My provider 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 the procedure or provide this item
- ☐ Other: _____

PROCEDURE/ITEM:	PROCEDURE CODE:	ESTIMATED COST:

Provider name: _____

Provider signature: _____ Date: _____