

Advance Member Notice

Migrated Members



Completion of this form acknowledges that the member is fully responsible for all charges associated with the professional or institutional 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.

Beginning July 1, 2018, and on group anniversary thereafter, this form can be used for members who have migrated to BCBSND's new claims processing system.

Procedure/Item/Service	(Estimated) Billed 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