Independence Blue Cross

MEMBER CONSENT FOR FINANCIAL RESPONSIBILITY FOR UNREFFERED/NON-COVERED SERVICES

MEMBER INFORMATION

MEMBER NAME: _____

MEMBER'S ID #: _____

PROVIDER INFORMATION

PROVIDER NAME: _____

PROVIDER'S ID #: _____

SPECIALTY OR DEPARTMENT: _____

TYPE OF SERVICE: _____

MEMBER MUST COMPLETE THIS SECTION

As a member of: Keystone Health Plan East (KHPE) Personal Choice® (PC)
(Circle one)

I understand that…
(Check the appropriate box):

- ❑ A referral from my Primary Care Physician is required for any and all non-Emergency outpatient hospital/specialist services. I acknowledge that I do not have a referral with me at this time, but I choose to receive the services without the required referral. I understand that without the appropriate referral, I will be held responsible for any payments incurred for these services. (KHPE)
- ❑ I understand that this is a non-covered service for which my insurance carrier will not make payment and I agree to be financially liable for any payments incurred for these services. (ANY)
- ❑ I understand that certain services are not covered when performed in an office setting (i.e., radiology, DME). If I choose to receive these services in a provider's office, rather than the appropriate network setting, I agree to be financially liable for any payments incurred for these services. (ANY)
- ❑ I understand that I will be responsible for all fees incurred if this visit or any other service precedes the effective date that has been assigned to my enrollment or my dependent's enrollment. (ANY)

_____ _____
Member's Signature *Employer Name (if applicable)*

_____ _____
Date *Employer Address (if applicable)*

_____ _____
Witness / Office Staff *City* *State* *Zip*

Independence Blue Cross offers products directly through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.