



# Acknowledgement of Financial Responsibility for the Cost of Equipment Upgrades and Supplies

**Provider:**

Please use this form for your patients who wish to receive health care services from you that may not be covered by their BlueCross BlueShield of Tennessee benefit plan. Acknowledgement of responsibility must include item/service provided and estimated cost.

**Member:**

Be sure to check the box by the option you choose below and sign the form. By signing this form, you agree to be financial responsibility for the payment of item/service provided below if not covered under your BlueCross plan. If you have questions about this notice or if the item/service is covered by your BlueCross plan, ask your provider or call the number on the back of your BlueCross ID card.

Provider \_\_\_\_\_ Provider Number \_\_\_\_\_

Patient Name \_\_\_\_\_ BlueCross ID Number \_\_\_\_\_

Date of Service	Service Description (S1001) Please list each item with cost.	Estimated Cost

**Reason(s) Service May Not Be Covered**


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**Choose one of the following options:**

**OPTION 1.** I've agreed to the item/service listed above and request the claim filed to BlueCross for an official decision on payment. If my BlueCross plan doesn't cover item/service, I understand I'm responsible for the cost of the item/service. If my BlueCross plan covers the item/service, I'll receive a refund for any payments for the cost of the item/service, less co-pays or deductibles.

**OPTION 2.** I don't want the item/service listed above. I understand I'm not responsible for payment.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_