blue of california

Member Advance Notice Form - Referral to Non-Preferred Provider

Your physician is referring you to a non-preferred/non-participating provider for services. If your Blue Shield of California or Blue Shield Life & Health Insurance Company health plan offers benefits for services rendered by non-preferred/non-participating providers, you may receive services from non-preferred/non-participating providers, but you may have higher out-of-pocket costs when accessing non-preferred/non-participating providers.

You do have the option of receiving services from a Blue Shield preferred provider in order to obtain the maximum benefits available under your health plan. If you would like to use a preferred provider, please ask your physician to arrange for the services to be provided by a preferred provider. If you have questions or wish to locate a preferred provider, contact Blue Shield Customer Service at the telephone number listed on the back of your identification card or log onto blueshieldca.com to search the online Preferred Provider Directory.

To be completed by the referring physician:

Type of referral:

- ☐ non-preferred/non-participating physician / specialist / other professional provider
- ☐ non-preferred/non-participating facility
  - ☐ ambulatory surgery center (ASC) ☐ dialysis center ☐ skilled nursing facility ☐ infusion center
- ☐ other non-preferred/non-participating provider
  - ☐ durable medical equipment (DME) company ☐ home health / home infusion company
  - ☐ other (please list)_____

referring physician's name:
patient's name:
member ID:
name of non-preferred/non-participating provider:
reason for referral to non-preferred/non-participating provider:

To be completed by the patient or patient's parent/legal guardian (if patient under age18):

By signing below, I acknowledge that I understand that the provider listed above is not a preferred provider with Blue Shield of California. I am also aware that I may be responsible for higher copayments and costs in excess of Blue Shield's allowable amounts, up to the provider's total billed charges, if I receive services from this non-preferred/non-participating provider. I was offered and declined the opportunity to select a Blue Shield preferred provider to provide these services and am voluntarily choosing to obtain services from this non-preferred/non-participating provider and accept financial responsibility for any additional cost for the service.

signature of patient or parent/legal guardian (if patient under age18):	
printed name of patient or parent/legal guardian (if patient under age18):	
date:	daytime phone number: