Member Acknowledgement of Financial Responsibility

Provider, please check one of the following:

Blue Shield has indicated that the services listed are not covered under your benefit plan.

Your benefits have not been verified. In the event that Blue Shield determines that the services listed are not covered under your benefit plan, you will be responsible for the cost of that service.

Provider: This form must be used for Blue Shield members who wish to receive healthcare services from you that may not be covered by their Blue Shield Benefit Plan. Acknowledgement of responsibility must include specific information regarding date of service, services provided, and billed amounts.

Member: Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below if:

- The services are not covered under your Blue Shield Benefit Plan, or,
- The services have not been otherwise approved for payment by Blue Shield.

Service Description:

(Any service not described as a covered benefit in the member's *Evidence of Coverage*.)

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Date of Service:

Billed Amount:

____

Member or Member's Legal Representative Name (Please Print)

____

Member or Member's Legal Representative Signature Date

____

Provider or Provider's Representative Name (Please Print)

____

Provider or Provider's Representative Signature Date

QUESTIONS?

Blue Shield Provider Customer Service: **(800) 541-6652**
Blue Shield Provider Information & Enrollment: **(800) 258-3091**