BLUE CROSS OF CALIFORNIA
MEMBER (PATIENT) RESPONSIBILITY AGREEMENT

Blue Cross of California ("Blue Cross") participating health care professionals/facilities ("Providers") are prohibited from charging Blue Cross members for any service, product or upgrade (collectively, "Service") that is deemed not medically necessary, unless the member specifically requests such Service and agrees in writing to be financially responsible for it. This waiver form shall be used to document the Member's agreement to be responsible for such Services. To be effective and valid, this document must be executed prior to the delivery of any non-medically necessary Service.

MEMBER (PATIENT) NAME:_____ **DOB:**_____

SUBSCRIBER ID:_____ **GROUP NO.:**_____

PROVIDER:_____

PROVIDER TAX ID:_____ **PROVIDER PHONE:**_____

MEMBER:

By signing below, I agree to pay Provider for those Services determined for the reason(s) specified below not to be covered under my Benefit Agreement:

- ☐ Not medically necessary;
- ☐ Primarily for comfort and convenience; or
- ☐ Otherwise not a covered benefit or excluded under my coverage

I understand that a Provider may not charge me for a Service determined to be not medically necessary unless I specifically agree to pay for it. I also understand that the Provider and/or I may appeal any determination that a Service is not medically necessary by filing a grievance or appeal with Blue Cross or the Department of Managed Health Care ("DMHC") pursuant to the grievance and appeals procedures described in my Benefit Agreement or Evidence of Coverage ("EOC"). I also understand that I may also have the right to Independent Medical Review through the DMHC, as described in my Benefit Agreement or EOC.

For the Services listed below, I also understand that I am responsible for the difference between the covered expense for any covered services and the Total Cost listed below, even though they may not be shown on my Explanation of Benefits (EOB) as my responsibility. If the Total Cost of the Service is not a covered expense under the applicable Benefit Agreement, I understand that I am responsible for the Total Cost.

Date of Service	Service, Product, or Upgrade	Total Cost	Member's (Patient's) Responsibility*

_____

Member/Subscriber Signature Date Signed

*In addition to being responsible for this amount, I understand that I will be billed and held responsible for any applicable copayment, deductible, and/or coinsurance as stated in my Member's Benefit Agreement.

PROVIDER:
Provider please send a completed copy of this waiver form with the initial claim to the claims address on the Member's (Patient's) identification card for appropriate claims processing. This does not represent a renegotiation of an already negotiated rate between Provider and Blue Cross.