



BlueCross BlueShield
of Texas

Out-of-Network Care - Enrollee Notification Form

☐ Blue Choice PPOSM

☐ Blue Advantage HMOSM
(for *Blue Advantage Plus* point-of-service benefit plan)

Enrollee Notification – You are free to choose a participating/preferred provider or an out-of-network provider. However, choosing an out-of-network provider may result in higher out-of-pocket expenses for you. We encourage you to call the Customer Service phone number provided on your membership ID card so a service representative can explain your possible greater financial liability when choosing an out-of-network provider. This potential liability includes an impact on deductibles, and your responsibility for amounts in excess of the Allowable Amount in your plan (the “balance bill”), which may be substantial. There is no balance bill for covered service rendered by network providers. By signing below, you acknowledge there is no benefit for a balance bill, and the potential financial consequence of receiving out-of-network services.

Using out-of-network providers results in no penalties, with the exception of the consequences mentioned above. Blue Cross and Blue Shield of Texas (BCBSTX) encourages you to research options for treatment to ensure the best possible care, at the best possible price.

Physician – It is essential that Blue Choice PPO and Blue Advantage Plus enrollees fully understand the impact of an out-of-network referral to a provider, hospital, ambulatory surgery center (ASC) or other facility that does not participate in their BCBSTX provider network.

Prior to referring a Blue Choice PPO or Blue Advantage Plus enrollee to an out-of-network provider for non-emergency services, network physicians must complete this form if such services are also available through an in-network provider. The referring network physician must provide a copy of the completed form to the enrollee, and retain a copy in his or her medical record files. Use of this form is subject to periodic audit to determine compliance with this administrative requirement outlined in the provider manuals.

Physician Name: _____

Enrollee Name: _____

Enrollee ID#: _____ Enrollee phone #: _____

BCBS Enrollee Signature: _____ Date: _____

Name of In-network provider option(s) discussed: _____

Name of out-of-network provider option discussed: _____

Reason for referring out-of-network: _____

PHYSICIAN DISCLOSURE: I or a family member has an ownership interest in or will benefit from the referral to the out-of-network provider above: Yes _____ No _____↑

I have reviewed this form with the patient/enrollee prior to treatment for which the referral is being made, and the patient/enrollee has acknowledged the information contained in this form and was offered a copy for his or her records.

Physician Signature

Date

This form cannot be used for a referral authorization form. **If there are no in-network options available, please contact BCBSTX Utilization Management at 855-896-2701.** A referral to an out-of-plan or out-of-network physician, professional provider, ambulatory surgery center, hospital or other facility, which is necessary due to network inadequacy or continuity-of-care, must be reviewed by BCBSTX Utilization Management **prior** to a BCBSTX patient receiving care.