BlueCross BlueShield of Montana

Advance Member Notification Form

Patient Name:	Patient Health Plan ID:	Patient Date of Birth:
Provider Name:	Provider NPI Number:	Provider Phone: Provider Fax:
Additional Provider:	Provider NPI Number:	Provider Phone: Provider Fax:
Additional Provider:	Provider NPI Number:	Provider Phone: Provider Fax:

You Need to Make a Choice About Receiving These Health Care Items or Services

Your health care provider has decided to provide services that Blue Cross and Blue Shield of Montana may determine per medical policy are not medically necessary or experimental, investigational, or unproven services. The fact that BCBSMT may not pay for these services does not mean that you cannot receive that service. To assist you in making informed decisions regarding your health care, if you decide to receive these services, please sign this form to indicate that **you have had a discussion with your health care provider about these services and your health care options** and you have agreed to receive services that BCBSMT may determine are not medically necessary or experimental, investigational, or unproven and will not pay for. By signing this form, if you obtain these services, you are agreeing to be financially responsible for any and all charges related to the services as outlined in this document if BCBSMT determines that these are not medically necessary covered or experimental, investigational, or unproven services.

NOTE: This AMN does not limit you from exercising your right to appeal a not medically necessary or experimental, investigational, or unproven claim denial per the terms and limitations of your member contract.

Item/Service/Procedure Code(s):	
Anticipated Date(s) of Service:	
Has a prior authorization or recommended clinical review been submitted?	
Prior authorization / recommended clinical review #:	
Reason for Potential Denial:	

The purpose of this form is to help you make an informed decision about whether you want to receive these items or services, knowing that you might be responsible for the entire cost of these services.

Estimated Cost = $ _____

What You Need to Do Now:

- Read this notice, so you can make an informed decision about your health care.
- Ask BCBSMT any questions that you may have after you finish reading.
- **Sign and Date This Notice**

YES, I want to receive these items or services.

I understand that these items or services may not be paid for by BCBSMT. Please submit my claim to BCBSMT. If BCBSMT deems the service not medically necessary or experimental, investigational, or unproven and denies payment, I agree to be personally and fully responsible for payment. I understand I can appeal BCBSMT's decision.

_____	_____
Date	Signature of patient or patient's authorized representative

NOTE: Your health information will be kept confidential by BCBSMT. Any information that we collect about you on this form will be kept confidential. If a claim for this service is submitted to BCBSMT, this form will be provided as required per BCBSMT policy. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in your Member Contract and/or Summary Plan Description. If you have medical questions regarding this notice, contact your health care provider. If you have questions related to coverage or claims processing, contact Customer Service at the number on the back of your health insurance ID card.