WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

P O Box 2266
Cheyenne, WY 82003
307.634.1393
800.442.2376

Advance Member Notice

FOR THE PATIENT

As a Blue Cross Blue Shield of Wyoming Member, I understand that I am fully responsible for all charges associated with the procedure/item/service I have requested below because this procedure/item/service may not be medically necessary and/or is not a covered benefit under my plan.

Procedure/Item/Service	CPT® Code	[Estimated] Billed Professional Charge

I acknowledge that I am voluntarily signing this statement, and that it is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) for any procedure/item/service listed above that is denied as non-covered by Blue Cross Blue Shield of Wyoming and will pay the provider as charged. I also understand that it is my choice to have the services provided at a future date and time by this provider.

Member Name: _____

Member ID Number: _____

Member Signature: _____ Date: _____

FOR THE PROVIDER

As a participating Blue Cross Blue Shield of Wyoming provider, I certify that I have informed my patient, _____, of the above. ***I acknowledge that BCBSWY medical policy, BCBSWY Participation Agreement provisions, and any other policies promulgated by BCBSWY, including any resulting decisions on financial responsibility, supersede this Advance Member Notice.*** This notice is not required for the member to receive medically appropriate and necessary covered services.

Provider Name: _____

Provider Signature: _____ Date: _____