BlueCross BlueShield of Texas

This form cannot be used as a referral authorization form. If there are no in-network provider options available, a referral authorization request for an out-of-network provider should be submitted by the referring physician through Availity® Authorizations & Referrals tool or or by contacting BCBSTX Medical Management at **1-855-896-2701**.

Out-of-Network Care - Enrollee Notification Form for Regulated Business

("TDI" is on the member's ID card)

☐ Blue Choice PPO℠ ☐ Blue Advantage HMO℠

(for Blue Advantage Plus HMO 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.

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 important for Blue Choice PPO and Blue Advantage Plus HMO enrollees to fully understand the financial impact of an out-of-network referral to a physician, professional provider, hospital, ambulatory surgery center or other facility that does not participate in their BCBSTX provider network.

Prior to referring a Blue Choice PPO or Blue Advantage Plus HMO enrollee to an out-of-network provider for non-emergency services, referring network physicians must complete this form if such services are also available through an in-network provider. The referring network physician should provide a copy of the completed form to the enrollee, and retain a copy in enrollee/patient's medical record files.

Physician Name: ______________________________

Enrollee Name: ______________________________

Enrollee ID#: ____________________ Enrollee phone #: ____________________

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

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

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, 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

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