ASHFORD CLINIC
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OUT OF NETWORK

Member Advance Notice Form for the Involvement of a Non-participating Provider

Your physician of other healthcare professional has decided to involve a non-participating physician, facility or other healthcare provider in your care. In order to assist you in making informed decisions regarding your healthcare, we ask that you sign this form to indicate that you have had a discussion with your physician or other healthcare professional about your option to utilize a participating provider and you have agreed to receive services from a non-participating provider despite the potential increased out-of-pocket costs associated with that decision.[1]

Please note that if you have out-of-network benefits under the terms of your benefit plan, you may utilize those benefits to receive services from a non-participating provider. However, we believe it is important that you understand that you may have higher out-of-pocket costs when using a non-participating provider based on your benefit plan. Please also note that if you do not have out-of-network benefits under the terms of your benefit plan and you receive services from a non-participating provider, you may be responsible for the entire cost of the services.

If you have questions or would like to find a participating provider that can perform the services you require, please ask your physician or other healthcare professional to arrange for the use of a participating provider. You can confirm the participation status of providers by contacting your Insurance Provider at the telephone number listed on your insurance ID card.

To be completed by the member's physician or other healthcare professional:

Physician/Healthcare Professional Name	
Physician/Healthcare Professional Tax ID#	
Member Name	
Member ID #	
Non-Participating Physician/Facility/ Healthcare Provider Name	
Type of Service non-Participating Provider will Render	
Date of Service	
Reason for Involving a Non-Participating Provider	

To be completed by the member or the member's legal guardian:

I am aware that the physician, facility or other healthcare provider listed above will be involved in my care on the date of the service listed above, and I understand that this healthcare provider is not a participating provider in my health insurance benefit plan network. **I was provided** and declined the opportunity to select a participating provider to provide the healthcare services indicated above and am voluntarily choosing to obtain services from a non-participating provider. **I am aware that I may be responsible** for any additional costs resulting from my use of a non-participating provider, if provided in my benefit plan. **I understand** that non-participating providers are generally prohibited from waiving member cost share amounts such as co-payments, deductibles and co-insurance.

_____ _____

Signature of Member, Parent (if the member is under age 18) or Legal Guardian — Date

_____

Printed Name of Member, Parent (if the member is under age 18) or Legal Guardian

[1] Participating healthcare providers are required to keep a copy of this completed from on file. Members may request a copy of this completed form from their participating provider.