

**WAIVER FORM  
FOR**

- **NON-REFERRED SERVICE**
- **NOT MEDICALLY NECESSARY SERVICE**
- **EXPERIMENTAL/INVESTIGATIVE SERVICE**

<p><b>I. Provider Information</b></p> <p>Provider Name: _____</p> <p>Practice Name: _____</p> <p>Phone: (____) _____</p> <p>Provider Number: _____</p>	<p><b>II. Patient Information</b></p> <p>Patient Name: _____</p> <p>Patient ID#: _____</p> <p align="center">(Prefix) <span style="float: right;">(Suffix)</span></p> <p>DOB: ____/____/____    Sex:    M            F</p>
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**III. Waiver Form Statement and Provider Signature**

The purpose of this waiver form is to inform Anthem Blue Cross and Blue Shield (Anthem BCBS) members, before they receive a medical service, that the service listed below is non-referred or not medically necessary or experimental/investigative. By signing this form, I, the provider acknowledge and agree that I have explained to the member that the service(s) listed are not a covered service(s).

\_\_\_\_\_

(Provider Signature) \_\_\_\_\_  
(Date)

**IV. Reason for Waiver Form**

<p><input type="checkbox"/> <b>Non-Referral Service</b></p> <p>HMO Members—Non-referred services are not covered by Anthem BCBS and, therefore, are the member’s responsibility.</p> <p>-----</p> <p><b>Patient Signature</b></p> <p>I have been informed by the provider indicated in Section I. in advance that the service(s) listed below are services that have not been referred by my primary care provider and are not covered. I understand and agree that I am responsible for payment of the provider’s charges for these services to the provider of service.</p> <p>Patient Signature: _____</p> <p>Date: _____</p>	<p><input type="checkbox"/> <b>Not Medically Necessary Service</b></p> <p><input type="checkbox"/> <b>Experimental/Investigative Service</b></p> <p>Not medically necessary and experimental/investigative services are not covered by Anthem BCBS and, therefore, are the member’s responsibility.</p> <p>-----</p> <p><b>Patient Signature</b></p> <p>I have been informed by the provider indicated in Section I. in advance that the service(s) listed below are services that are not medically necessary or are services that are experimental/investigative and are not covered. I understand and agree that I am responsible for payment of the provider’s charges for these services to the provider of service.</p> <p>Patient Signature: _____</p> <p>Date: _____</p>
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**V. Service(s) To Be Provided**

Date(s) of Service	Procedure/Service	Procedure Code*	Amount Charged
____/____/____	_____	_____	_____
____/____/____	_____	_____	_____
____/____/____	_____	_____	_____
____/____/____	_____	_____	_____

\*If applicable

