



Financial Waiver Form

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This form helps you understand when you may have to pay for a service your provider suggests. Sometimes a service may not be needed for your health (medically necessary), or it may be considered experimental, or it is not a service your plan allows. This form will tell you the cost you might have to pay. You will be asked to read it and sign it before you get the service. If you cannot sign it, your provider will explain the information to you and write a note in your medical record. If a service is not listed on this form, you will not be billed for it.

Patient Name: _____ **Date:** _____

Member ID Number: _____ **Provider Name:** _____

Notice of Personal Financial Obligation - Please read before signing

I request _____ (*Provider*) to refrain from submitting any claims or information to Blue Cross and Blue Shield of Nebraska (BCBSNE) related to the service(s) listed below and I agree to assume all payment obligations for such service without regard to the health coverage I have available to me through BCBSNE.

I understand that _____ (*Provider*) has a contractual obligation to submit claims to BCBSNE and agree to waive any future legal and/or contractual rights regarding insurance or health plan coverage for services provided.

Date of Service: _____
Procedure Code(s): _____
HCPS Code: _____
Description of Services:

I understand that I will be held personally responsible for approximately \$ _____ based on this request and waive any benefits I have under my applicable insurance or health plan for these services. This amount is an approximation only, based on the service(s) scheduled to be provided.

Printed Name: _____

Date: _____

Signature: _____