Privacy Waiver Form

Patient Name		**Date**	
BCBSNE ID Number		**Provider Name**	

The provider must document in the patient record the discussion with the patient regarding the following service(s) for each instance in which this waiver is used. If the patient should call about his or her claim not being filed, Blue Cross and Blue Shield of Nebraska will request a copy of this form.

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 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 Blue Cross and Blue Shield of Nebraska.

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

Date of Service	

Procedure Code(s)	
HCPCS 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 coverage for these services. This amount is an approximation only, based on the service(s) scheduled to be provided.

Printed Name	
Date	
Signature	