Non-Participating Provider Advance Member Notification (AMN) Form (Commercial)

At ConnectiCare, we encourage you to use a participating physician, facility or other health care provider (including laboratory/pathology) because using a non-participating physician, facility or other health care provider may result in higher out-of-pocket costs to you, our member.

You are being asked to sign this consent form because your physician is sending you to or arranging for you to receive services from a non-participating physician, facility or other health care provider.

All non-participating provider/facility claims will be treated as out-of-network, and will not be paid with in-network benefits under your benefit plan. If your benefit plan includes out-of-network benefits, the out-of-network costs will apply. If your plan does not include out-of-network benefits, you will be responsible for the entire cost of the service(s).

To be completed by the referring network physician or health care professional:

Referring Provider's Name:	Referring Provider's Tax ID Number:
Patient Name:	**ConnectiCare Member ID Number:**
Non-Participating Physician/Provider Name:	**Specialty:**
Non-Participating Facility Name:	**Facility Type:**
Reason for Non-Par referral:	**Date of service:**

To be completed by patient or legal guardian:

By placing my signature on this waiver form below, I acknowledge the following:

1. I am aware that the physician/provider and/or facility listed will be involved in my care and that this physician/provider and/or facility does **not** participate with ConnectiCare
2. I was provided the opportunity to contact ConnectiCare before obtaining these services to confirm my benefits for these out-of-network services and to obtain the names of participating physicians/providers and/or facilities that can provide the recommended service or procedure
3. I understand that I may be responsible for additional costs for all services provided by the non-participating physician, facility or other health care provider, as specified in my benefit contract
4. I understand that out-of-network care providers/facilities are generally prohibited from waiving member cost share amounts such as copayments, deductibles and coinsurance.
5. I am voluntarily choosing to obtain the service or procedure from the non-participating physician, facility or other health care provider named above

Printed Name of Patient or Parent(<18 years of age)/Legal Guardian:	Daytime Phone Number:
Signature of Patient or Parent (<18 years of age)/Legal Guardian:	**Date:**