Acknowledgement of Financial Responsibility Form

Member Acknowledgement of Financial Responsibility

Provider: This form must be used for Blue Shield members who wish to receive healthcare services from you that may not be covered by their Blue Shield Benefit Plan.

Member: Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below if:

- The services are not covered under your Blue Shield Benefit Plan; or,
- The services have not been otherwise approved for payment by Blue Shield.

Services: (Any service not described as a covered benefit in the member's Evidence of Coverage.)

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Member or Member's
Legal Representative Name (Please Print)

______________________________ Date: ______________
Member or Member's
Legal Representative Signature

Provider: ______________________________

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Provider or Provider Representative Name
(Please Print)

______________________________ Date: ______________
Provider or Provider Representative Signature