Ancillary and Behavioral Health Provider
Non-Covered Service Waiver Form

For the Member

As a Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Healthcare or Tufts Health Plan member, I understand that I am responsible for all costs associated with the procedure/item listed below. My provider has informed me that BCBS, HPHC or Tufts Health Plan does not pay for this procedure/item because:

- ❑ The procedure or item is not considered medically necessary
- ❑ It is not a covered benefit under my plan
- ❑ He/she is not contracted to perform/provide this procedure/item
- ❑ Other ____
  (to be completed by provider, if applicable)

Some insurance plans with BCBS, HPHC and Tufts Health Plan do not cover speech therapy services related to developmental problems. They cover acute conditions (medically necessary) only. We will be happy to submit your therapy bills to these insurance plans but in the event that they do not cover services, you will be responsible for payment **even though they state "member is not responsible."** Under some circumstances you will be expected to pay for therapy at the time of service and you will be reimbursed, should insurance pay.

Member Name: ____

Member ID Number: ____________________________________

Member Signature: ______________________________________ Date: __________________

For the Provider

As a participating BCBS, HPHC or Tufts Health Plan provider, I certify that I have informed my patient, __________________________________, that BCBS, HPHC or Tufts Health Plan does not allow payment for the procedure/item listed below because:

- ❑ The procedure or item is not considered medically necessary
- ❑ It is not a covered benefit under the member's plan
- ❑ I am not contracted to perform procedure or provide this item
- ❑ Other ____

Procedure/Item:	Procedure Code:

Provider Name: ____

Provider Signature: ____ Date: ______________