Ancillary and Behavioral Health Provider
Non-Covered Service Waiver Form

For the Member

As a Blue Cross Blue Shield of Massachusetts member, I understand that I am responsible for all costs associated with the procedure/item listed below. My provider has informed me that Blue Cross Blue Shield of Massachusetts 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)

Member Name: _____

Member ID Number: _____

Member Signature: _____ Date: _____

For the Provider

As a participating Blue Cross Blue Shield of Massachusetts provider, I certify that I have informed my patient, _____, that Blue Cross Blue Shield of Massachusetts 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: _____