Empire BlueCross BlueShield

Advance Patient Notice Form

Your physician is referring you to, or arranging for you to receive services from, a non-participating physician, provider or facility for certain healthcare services. You have the right to receive services at a participating facility or by a participating physician or provider in order to obtain full benefits under your health coverage. If you have questions or would like to locate an in-network physician, provider or facility to provide the service or procedure, please contact Empire Customer Service at the telephone number listed on the back of your Empire identification card.

To be completed by the referring physician:	
Please check the type of referral (check all that apply): ☑ **Non-Par Physician or Provider** ☐ **Non-Par Facility** ☐ **Both**	
Referring Physician Name: ANDREW D. PEARLE, MD	**NPI #:** 142 707 1778
Patient Name:	**Member ID#:**
Non-Participating Physician Name: (OFFICE USE ONLY) NICOLE FEIN/NICHOLAS ABEL/OTHER -	**Specialty:** PHYSICIAN'S ASSISTANT
Non-Participating Facility Name: N/A	**Type of Facility:**
Reason for non-par referral: MD OUT-OF-OFFICE or ASSISTANT NEEDED IN THE OPERATING ROOM	**Date of Service:** EFFECTIVE FROM DATE SIGNED - NO EXPIRATION DATE

To be completed by the patient or patient's legal guardian:

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

1. I am aware that the non-participating facility/provider that will be involved in my care does not participate with Empire.
2. I understand that I may be responsible for additional costs for all services provided by the non-participating facility/provider, as specified in my benefit contract.
3. I was given an opportunity to contact Empire before obtaining these services to confirm my benefits for these non-network services and to obtain names of participating facilities and/or participating providers that can provide the recommended service or procedure.
4. I understand that absent special circumstances (e.g., financial hardship), the non-participating facility/provider is prohibited from waiving co-payments, deductibles, coinsurance or other member cost sharing amounts.
5. I am voluntarily choosing on behalf of myself or my child/legal guardian to obtain the service or procedure from the non-participating facility and/or physician.

Signature of Patient, Parent (if patient under age 18) or Legal Guardian:	
Printed name of Patient, Parent (if patient under age 18) or Legal Guardian:	
Date:	**Daytime Phone Number:**

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