

INSTRUCTIONS

Complete this form ONLY for patients enrolled in Horizon Blue Cross Blue Shield of New Jersey plans that include out-of-network benefits. DO NOT use this form for patients enrolled in Horizon BCBSNJ plans that DO NOT include out-of-network benefits (including, but not limited to, Horizon HMO plans, Horizon EPO plans, OMNIASM Health Plans, Medicare Advantage HMO plans).

When treating a patient enrolled in a Horizon BCBSNJ plan that includes out-of-network benefits, participating doctors and other health care professionals are **required** to:

1. **Complete this form:**
 - Before referring a patient to an out-of-network doctor, facility or other health care provider
 - Before sending a patient's laboratory sample to an out-of-network clinical laboratory
 - Before you use an out-of-network doctor (e.g., an anesthesiologist, co-surgeon or assistant at surgery) to perform a service.
2. **Have a discussion with your patient** (or his/her parent, guardian or personal representative) **before** using an out-of-network provider to advise that:
 - An out-of-network doctor, facility or other health care provider will be involved in your patient's care
 - Claims for services provided by out-of-network providers will be processed at your patient's out-of-network level of benefits
 - Your patient will be responsible for his/her out-of-network cost-sharing amounts (copayments, deductible and coinsurance amounts, as applicable) AND the difference between Horizon BCBSNJ's allowance¹ for eligible services and the out-of-network provider's billed charges.
3. **Have your patient** (or his/her parent, guardian or personal representative) **initial/sign** this form to attest that the patient:
 - Is aware of and agrees to the use of an out-of-network doctor, facility or other health care provider
 - Understands the financial impact of the decision to use an out-of-network doctor, facility or other health care provider
4. **Retain the original completed form** in the patient's medical record and provide a copy to your patient.

FOR PATIENT REVIEW:

How will using an out-of-network doctor, hospital or other health care provider impact me?

Horizon BCBSNJ encourages you to use in-network doctors, facilities and other health care providers to help you maximize your benefits and save you money. If you choose to use an out-of-network doctor, facility or other health care provider, it's important that you understand the financial impact of this decision.

When you use your out-of-network benefits, in addition to being responsible for any out-of-network cost-sharing amounts (copayments, deductible and coinsurance amounts, as applicable), you are also responsible for the difference between Horizon BCBSNJ's allowance¹ for eligible services and the out-of-network provider's total billed charges.

Please review the example in the table below that compares costs of using an in-network surgery center with using an out-of-network surgery center. *This example is for illustrative purposes only. Your benefits may vary.*

| | In-Network surgery center | Out-of-Network surgery center |
|---|---------------------------|--|
| Surgery center's billed charges | \$5,000 | \$5,000 |
| Horizon BCBSNJ's allowance¹ | \$1,500 | \$1,500 |
| Patient cost-sharing | \$35 copayment | \$500 deductible and \$200 coinsurance (\$200 coinsurance = 20% of the \$1,000 left after the deductible) |
| Horizon BCBSNJ pays | \$1,465 | \$800 |
| You pay | \$35 | \$4,200 |

In this example:

- **Using an out-of-network surgery center**, after you meet your \$500 deductible, you are responsible for \$200 in coinsurance and the difference between what Horizon BCBSNJ pays (\$800) and the out-of-network surgery center's billed charges (\$3500). Using your out-of-network benefits, you pay \$4,200.
- **Using an in-network surgery center**, you only pay a \$35 copayment. The in-network surgery center will not bill you for more than \$35. Using your in-network benefits saves you \$4,165.

(continues)

¹ An **allowance** is the amount that Horizon BCBSNJ has determined to be appropriate reimbursement for a given eligible service or supply. When our allowance is lower than an in-network provider's submitted charges, that provider agrees to accept our allowance – less any member cost-sharing amounts (copayments, deductible and/or coinsurance). Out-of-network providers have no agreement with us and do not accept our allowance as payment-in-full. Patients who use out-of-network providers are responsible for the total billed charges (less any amounts Horizon BCBSNJ pays).



Horizon Blue Cross Blue Shield of New Jersey

Consent for Referral to an Out-of-Network Provider Form

TO BE COMPLETED BY THE REFERRING DOCTOR/OTHER HEALTH CARE PROFESSIONAL:

The referring doctor/other health care professional must complete this section and hold a discussion with his/her patient prior to out-of-network services being provided.

Referring Doctor/Other Health Care Professional Name _____ NPI _____

Phone _____ Email _____

Patient Name _____ Patient DOB _____

Subscriber Name _____ Subscriber ID # _____

Out-of-Network Provider being referred to Name _____ Provider Type _____

Out-of-Network Provider Address _____

Service to be rendered (e.g. labs, dialysis, anesthesia) by out-of-network provider _____

I recommended/offered my patient the opportunity to use an in-network provider. Yes No

Reason for using an out-of-network provider:

- Provider specialty is not available within Horizon BCBSNJ's participating network
- Provider preference
- Member preference/convenience
- Other (please explain) _____

I, the referring doctor/other health care professional:

- DO DO NOT Have a financial interest in the referred-to out-of-network provider (noted above).
- DO DO NOT Receive compensation from the referred-to out-of-network provider (noted above).
- DO DO NOT Understand that using an out-of-network provider will result in increased financial responsibility for my patient.

TO BE COMPLETED BY THE PATIENT (OR THE PATIENT'S PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE):

After a discussion with your referring doctor/other health care professional about the details completed above (and before out-of-network services are provided), please review and initial the statements and sign below.

By initialing, signing and dating below, I, the member (or his/her parent, guardian or designated personal representative), attest that I am aware and understand the following:

InitialMy referring doctor/other health care professional completed the details on this form and spoke to me about using the out-of-network doctor, facility or other health care provider listed above.

InitialThe doctor, facility or other health care provider to be involved in my care **is not** in-network and/or **does not** participate with my Horizon BCBSNJ health insurance plan.

InitialMy referring doctor/other health care professional offered me the opportunity to use an in-network doctor, facility or other health care provider, but I declined this offer.

InitialClaims from an out-of-network doctor, facility or other health care provider will be processed at my out-of-network level of benefits. I will be responsible for all out-of-network cost-sharing amounts (applicable copayments, deductible and/or coinsurance), as well as the difference between Horizon BCBSNJ's allowance¹ and the out-of-network provider's total billed charges.

InitialIf services *were* provided by an in-network doctor, facility or other health care provider, that my in-network level of benefits would apply and that I would *not* be billed for any amounts in excess of Horizon BCBSNJ's allowance¹.

Initial**Horizon BCBSNJ may contact me in the future to ask about amounts I paid to the out-of-network doctor, facility or other health care provider in question.**

Signature of Patient, Parent (if the member is under age 18) or Legal Guardian Date

¹ An **allowance** is the amount that Horizon BCBSNJ has determined to be appropriate reimbursement for a given eligible service or supply. When our allowance is lower than an in-network provider's submitted charges, that provider agrees to accept our allowance – less any member cost-sharing amounts (copayments, deductible and/or coinsurance). Out-of-network providers have no agreement with us and do not accept our allowance as payment-in-full. Patients who use out-of-network providers are responsible for the total billed charges (less any amounts Horizon BCBSNJ pays).



Horizon Blue Cross Blue Shield of New Jersey

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Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Horizon BCBSNJ does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Horizon BCBSNJ provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Information written in other languages

If you need these services, contact Horizon BCBSNJ's Director of Regulatory Compliance at the phone number, fax or email listed below.

If you believe that Horizon BCBSNJ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Horizon BCBSNJ – Director, Regulatory Compliance
Three Penn Plaza East, PP-16C
Newark, NJ 07105
Phone: 1-800-658-6781
Fax: 1-973-466-7759
Email: ComplianceAndEthicsOffice@HorizonBlue.com

You can file a grievance in person, or by mail, fax or email. If you need help filing a grievance, Horizon BCBSNJ's Director of Regulatory Compliance is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

Office for Civil Rights Headquarters
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or 1-800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.



Horizon Blue Cross Blue Shield of New Jersey

If you need help understanding this Horizon Blue Cross Blue Shield of New Jersey information, you have the right to get help in your language at no cost to you. To talk to an interpreter, please call **1-800-355-BLUE (2583)** during normal business hours.

Spanish (Español): Si necesita ayuda para comprender esta información de Horizon Blue Cross Blue Shield of New Jersey, usted tiene el derecho de obtener ayuda en su idioma sin costo alguno. Para hablar con un intérprete, sírvase llamar al **1-855-477-AZUL (2985)** durante el horario normal de trabajo.

Chinese (中文): 如果您需要幫助來理解這份新澤西州地平線藍十字藍盾 (Horizon Blue Cross Blue Shield of New Jersey) 資料, 您有權免費獲得以您的語言提供的協助。欲聯絡翻譯人員, 請於上班時間致電 **1-800-355-BLUE (2583)**。

Korean (한국어): 가입자는 Horizon Blue Cross Blue Shield of New Jersey에 관한 정보를 이해하기 위해 주로 사용하는 언어로 무료로 도움을 받을 권리가 있습니다. 통역사의 도움을 받으려면 정상 업무 시간 동안에 **1-800-355-BLUE (2583)**로 전화해 주십시오.

Portuguese (Português): Se precisar de ajuda para entender estas informações da Horizon Blue Cross Blue Shield of New Jersey, você tem o direito de receber gratuitamente assistência no seu idioma. Para falar com um intérprete, ligue para: **1-800-355-BLUE (2583)** no horário normal de trabalho.

Gujarati (ગુજરાતી): જો તમને આ ન્યુ જર્સી માહિતીનાં હોરાઈઝન્સ બ્લૂ ક્રોસ બ્લૂ શીલ્ડને સમજવા મદદની જરૂર હોય તો, તમને તમારી ભાષામાં કોઈ પણ ખર્ચ વગર મદદ મેળવવાનો અધિકાર છે. કોઈ દુભાષિયા સાથે વાત કરવા, કૃપા કરીને સામાન્ય બિઝનેસ ક્લાકો દરમિયાન **1-800-355-BLUE (2583)** પર ફોન કરો .

Polish (Polski): Jeżeli potrzebujesz pomocy, aby zrozumieć informacje planu Horizon Blue Cross Blue Shield of New Jersey, masz prawo poprosić o bezpłatną pomoc w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer **1-800-355-BLUE (2583)** podczas normalnych godzin pracy.

Italian (Italiano): Se vi serve aiuto per capire queste informazioni della Horizon Blue Cross Blue Shield of New Jersey, avete diritto ad assistenza gratis nella vostra lingua. Per parlare con un interprete, siete pregati di telefonare al numero **1-800-355-BLUE (2583)** durante le normali ore d'ufficio.

Tagalog (Tagalog): Kung kailangan mo ng tulong sa pag-unawa nitong impormasyon ng Horizon Blue Cross Blue Shield of New Jersey, may karapatan kang humingi ng tulong sa iyong wika nang walang gastos sa iyo. Upang makipag-usap sa isang taga-interpret, mangyaring tumawag sa **1-800-355-BLUE (2583)** sa loob ng karaniwang mga oras ng negosyo.

Russian (Русский язык): Если вам необходима помощь в разъяснении этой информации, предоставленной компанией Horizon Blue Cross Blue Shield of New Jersey, у вас есть право на получение помощи на вашем родном языке бесплатно. Для связи с переводчиком звоните по номеру телефона **1-800-355-BLUE (2583)** в обычные рабочие часы.

Haitian Creole (Kreyòl ayisyen): Si ou bezwen èd pou konprann enfòmasyon sou Horizon Blue Cross Blue Shield of New Jersey, ou gen dwa pou jwenn èd nan lang natifnatal ou gratis. Pou pale avèk yon entèprèt, tanpri rele nimewo **1-800-355-BLUE (2583)** pandan lè nòmal biznis.

Hindi (हिंदी): यदि आपको न्यू जर्सी की इस होराइजन ब्लू क्रॉस ब्लू शील्ड सूचना को समझने में सहायता की ज़रूरत है, तो आपके पास मुफ्त में अपनी भाषा में सहायता पाने का अधिकार है। किसी दुभाषिए से बात करने के लिए, कृपया सामान्य कार्य समय के दौरान **1-800-355-BLUE (2583)** पर कॉल करें।

Vietnamese (Tiếng Việt): Nếu cần được giúp đỡ để hiểu rõ thông tin này của Horizon Blue Cross Blue Shield of New Jersey, quý vị có quyền được giúp đỡ bằng ngôn ngữ của mình miễn phí. Xin gọi số **1-800-355-BLUE (2583)** trong giờ làm việc để nói chuyện với người thông dịch.

French (Français): Si vous avez besoin d'assistance pour comprendre ces informations au sujet de Horizon Blue Cross Blue Shield of New Jersey, vous avez le droit d'obtenir de l'aide dans votre langue, sans aucun frais. Pour parler avec un interprète, veuillez appeler le **1-800-355-BLUE (2583)** pendant les heures normales de bureau.

Navajo (Diné): Díí New Jersey bił hahoodzo Horizon Blue Cross Blue Shield, t'áá ninizaad k'ehjí baa hane'íí bik'i diitjìh bee shiká' a' doowoł nínízingo éí bee ná'ahoot'i' dóo doo bááh ílíní da. Ata' halne'é ła' bich'i' hadeesdzih nínízingo t'áá shóqdí **1-800-355-BLUE (2583)** jį' nida'anishgo oolkiłí bik'ehgo hodíłnih.

Arabic (عربي): إذا كنت بحاجة إلى المساعدة في فهم معلومات Horizon Blue Cross Blue Shield of New Jersey لديك الحق في الحصول على المساعدة بلغتك دون تحمّل أيّة تكلفة. للتكلم مع مترجم، يرجى الاتصال خلال ساعات العمل العادية بالرقم **1-800-355-BLUE (2583)**.

Urdu (اردو): اگر آپ کو نیوجرسی انفارمیشن کے اس آسمانی نیلے رنگ والے تیز نیلے رنگ والے شیلڈ کو سمجھنے میں مدد کی ضرورت ہے تو، آپ کو اپنی زبان میں بغیر کسی خرچ کے مدد حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، براہ کرم، معمول کے کاروباری اوقات میں **1-800-355-BLUE (2583)** پر کال کریں۔