Horizon

Member Referral Consent Form: Using an Out-of-Network Provider for Medical Injectable Drugs

PRESCRIBING PRACTITIONER INSTRUCTIONS:

Complete this form ONLY for patients enrolled in Horizon BCBSNJ plans that include out-of-network benefits. This form does NOT apply to and should NOT be used 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, OMNIA$_{SM}$ Health Plans, Medicare Advantage HMO plans).

When you prescribe medical injectable drugs for a patient enrolled in a Horizon BCBSNJ plan that includes out-of-network benefits to be provided or administered by an out-of-network specialty pharmacy or home health care provider, you are **required**[1] to:

1. **Complete this form before using** an out-of-network specialty pharmacy or home health care provider
2. **Have a discussion with your patient** (or his/her parent, guardian or personal representative) **before** using an out-of-network specialty pharmacy or home health care provider to provide/administer medical injectable drugs to advise that:
   - An out-of-network specialty pharmacy or home health care provider will be involved in your patient's care
   - Claims for services provided by an out-of-network specialty pharmacy or home health care provider 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 allowance[2] 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 specialty pharmacy or home health care provider
   - Understands the financial impact of the decision to use an out-of-network specialty pharmacy/home health care provider
4. **Once the form is completed and signed:**
   - Retain the original completed form in your patient's medical record
   - Provide a copy to your patient
   - Fax a copy to Horizon Pharmacy Services at **1-973-274-2285**

(Continues)

[1] Participating providers are required to complete this form in compliance with *Out-of-Network Referral Policy*. Nonparticipating providers, though not required, are asked to complete this form to help ensure that their patients receive the services they require while maximizing their benefits and saving them money.

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FOR PATIENT REVIEW:
How will using an out-of-network specialty pharmacy or home 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 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 allowance[2] 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 specialty pharmacy provider with using an out-of-network specialty pharmacy provider.

This example is for illustrative purposes only. In this example, the in-network allowance is based on the drug's Average Wholesale Price ($43 per unit). The out-of-network allowance is based on 90% of Fair Health ($160 per unit). Your benefits and the actual allowances used by your health insurance plan may vary.

	In-Network Provider	Out-of-Network Provider
Billed charges for 120 units of Gamunex®-c	$23,000.00	$23,000.00
Horizon BCBSNJ's allowance[2]	$5,160.00 ($43 per unit)	$19,200.00 ($160 per unit)
Patient cost-sharing	$0.00	$100.00 deductible and $3,820.00 coinsurance (20%)
Horizon BCBSNJ pays	$5,160.00	$15,280.00
You pay	$0.00	$7,720.00

In this example:

- **Using an out-of-network** specialty pharmacy provider, after you meet your $100 deductible, you are responsible for $3,820.00 in coinsurance and the difference ($3,800.00) between the amount Horizon BCBSNJ pays ($15,280.00) and the out-of-network provider's billed charges ($23,000.00).

  Using your out-of-network benefits, you pay $7,720.00.

- **Using an in-network** specialty pharmacy provider, you pay nothing. The in-network specialty pharmacy will not bill you for anything.

  Using your in-network benefits saves you $7,720.00.

(Continues)

[2] *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).*

RESET

Member Referral Consent Form:
Using an Out-of-Network Provider for Medical Injectable Drugs

To be completed by the Prescribing Practitioner:

When medical injectable drugs are to be provided to a patient enrolled in a Horizon BCBSNJ plan that includes out-of-network (OON) benefits by an OON specialty pharmacy or home health care provider, you must complete this section and hold a discussion with your patient prior to these OON services being provided.

Prescribing Practitioner _____ NPI _____

Phone _____ Email _____

Patient Name _____ Patient DOB _____

Subscriber Name _____ Subscriber ID # _____

OON Provider Name _____ Provider Type _____

OON Provider Address _____

Drug to be provided/administered by OON 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 preference
☐ Member preference/convenience
☐ Other (*please explain*) _____

I, the referring doctor/other health care professional:
☐ DO ☐ DO NOT Have a financial interest in the OON provider (noted above).
☐ DO ☐ DO NOT Receive compensation from the OON provider (noted above).
☐ DO ☐ DO NOT Understand that using an OON provider will result in higher financial responsibility for my patient.

To be completed by the Patient (or the Patient's Parent, Guardian or Personal Representative):

By initialing, signing and dating below, I, the member (or parent, guardian or personal representative), attest that I had a discussion with my doctor about the details completed above (and before out-of-network services are provided), and that I am aware of and understand the following:

____ My doctor completed this form and spoke to me about using the out-of-network (OON) provider above.

____ The provider to be involved in my care **is not** in-network and **does not** participate with my Horizon BCBSNJ health insurance plan.

____ My doctor offered me the opportunity to use a participating provider, but I declined this offer.

____ Claims from this OON provider will be processed at my OON level of benefits. I will be responsible for all OON cost-sharing amounts (copayment/deductible/coinsurance), and the difference between Horizon BCBSNJ's allowance[2] and the OON provider's total billed charges.

____ If services *were* provided by an in-network provider, my in-network level of benefits would apply and I would *not* be billed for any amounts in excess of Horizon BCBSNJ's allowance.[2]

____ **Horizon BCBSNJ may contact me in the future to ask about amounts I paid to the OON specialty pharmacy or home health care provider above.**

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

[2] *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).*

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Horizon BCBSNJ provides free aids and services to people with disabilities (e.g. qualified language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

Contacting Member Services
Call Member Services at **1-844-498-9393** (TTY **711**) **or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues.**

Filing a Section 1557 Grievance
If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to:

Horizon BCBSNJ
Civil Rights Coordinator
PO Box 820
Newark, NJ 07101

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, online at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail at **U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201** or by phone at **1-800-368-1019** or **1-800-537-7697** (TDD). OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Language assistance
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-498-9393** (TTY **711**).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-844-498-9393**（TTY 711）.
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-844-498-9393 (TTY 711)번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-844-498-9393** (TTY **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-844-498-9393** (TTY **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-844-498-9393** (TTY **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-844-498-9393** (TTY **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-**844-498-9393** (رقم هاتف الصم والبكم 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-844-498-9393** (TTY **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-844-498-9393** (телетайп **711**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-844-498-9393** (TTY **711**).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपकेलिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-844-498-9393 (TTY **711**) पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-844-498-9393** (TTY **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-844-498-9393** (ATS **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-844-498-9393 (TTY **711**).