Braven HEALTH

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

RESET

INSTRUCTIONS

Complete this form ONLY for patients enrolled in Braven Health[SM] plans that include out-of-network benefits [i.e., Braven Medicare Choice (PPO), Braven Medicare Freedom (PPO), Braven Medicare Group (PPO) or Braven Medicare Access Group (HMO-POS)].

DO NOT use this form for patients enrolled in the Braven Medicare Plus (HMO) plan which does not include out-of-network benefits.

When treating a patient enrolled in a Braven Health 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).

3. **Have your patient** (or his/her 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.

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

We encourage you to use in-network doctors, facilities and other health care providers to help you maximize your benefits and save you money. If you make the choice 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, you are responsible for all appropriate and applicable cost-sharing amounts (copayments, deductible and coinsurance amounts).

- If your cost sharing is a copayment (a set amount of dollars, for example, $15), then you pay only that amount for covered services from a provider.
    - Please note that you will generally have higher copayments when you obtain care from out-of-network providers.
- If your cost sharing includes deductible and coinsurance, then you will not pay more than those amounts as applicable. However, your deductible and coinsurance amounts will depend on which type of provider you see:
    - If you receive covered services from a Braven Health participating provider, you pay the in-network coinsurance percentage multiplied by our contracted allowance for that service (as determined in the contract between the provider and us).
    - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.

As a Braven Health plan member, you only have to pay your cost-sharing amount when you receive services covered by your Braven Health Plan. Providers are not allowed to add additional separate charges, called "balance billing." If you believe a provider has "balance billed" you, please call the Member Services phone number on the back of your Braven Health ID card.

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THIS PAGE 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.

Name of Referring Practitioner _____

NPI _____

Phone _____ Email _____

Patient Name _____ Patient DOB _____

Subscriber Name _____ Subscriber ID # _____

Name of OON provider being referred to _____

Provider Type _____

Address _____

Service to be rendered by OON provider _____
(*e.g. labs, dialysis, anesthesia*)

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.

THIS PAGE TO BE COMPLETED BY:
THE PATIENT (OR THE PATIENT'S 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 to the each statement and signing and dating below, I, the member (or his/her designated personal representative), attest that I am aware and understand the following:

_____ My 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.

_____ The doctor, facility or other health care provider to be involved in my care **is not** in-network and/or **does not** participate with my Braven Health insurance plan.

_____ My 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.

_____ Claims 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).

_____ If 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 out-of-network cost-sharing amounts.

_____ 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 (or the patient's designated personal representative) Date