

**WAIVER**

**PHYSICIAN NOTICE:**

Arkansas Blue Cross and Blue Shield will not cover services that it determines are not medically necessary or that it classifies as either experimental or investigational in nature. If Arkansas Blue Cross determined that a particular service, although it would otherwise be covered, is not medically necessary or is experimental or investigational under Arkansas Blue Cross benefit plan, Arkansas Blue Cross will deny payment for that service. I believe that, in your case, Arkansas Blue Cross is likely to deny payment for:

\_\_\_\_\_ for the following reasons:  
\_\_\_\_\_.

The charge for this service will be \_\_\_\_\_.

**MEMBER AGREEMENT:**

"I have been notified by my physician that he or she believes that, in my case, Arkansas Blue Cross is likely to deny payment for the services identified above, for the reasons stated. If Arkansas Blue Cross denies payment for lack of medical necessity or on grounds of the experimental or investigational nature of the services, I agree that I will not look to Arkansas Blue Cross to cover these services and that I shall be personally and fully responsible for payment for all such services including any follow-up services that may be required to complete the treatment or to repair any damage or address any complication of the treatment.

\_\_\_\_\_  
Member's signature

Date: \_\_\_\_\_