

Patient's Name: \_\_\_\_\_ Blue Cross ID#: \_\_\_\_\_

**ADVANCE BENEFICIARY NOTICE – Blue Cross**

We expect that Blue Cross will not pay for the item or service that is described below. The fact that Blue Cross may not pay for a particular service does not mean that you should not receive it. There may be a good reason that your physician recommended it.

**Item/Service:** 76093 MRI, Breast with and/or without contrast, uni-lateral  
*(circle one)*  
76094 MRI, Breast with and/or without contrast, bi-lateral

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Blue Cross probably won't pay.
- Ask how much the service or item will cost you : **(Estimated Cost 76093 \$ 1200.00 )** } Circle One  
**(Estimated Cost 76094 \$ 1600.00)**

**Option 1. YES.** I want to receive these items or services.  
I understand that Blue Cross will not decide whether to pay unless I receive these items or services. Please submit my claim to Blue Cross. I understand that you may bill me for items or services and that I may have to pay the bill while Blue Cross is making its decision. If Blue Cross does pay, you will refund to me any payments I made to you that are due me. If Blue Cross denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Blue Cross' decision.

**Option 2. NO.** I have decided not to receive these items or services.  
I will not receive these items or services. I understand that you will not be able to submit a claim to Blue Cross and that I will not be able to appeal your opinion that Blue Cross won't pay.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or person acting on Patient's behalf

*Note: Your health information will be kept confidential. Any information we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Blue Cross your health information on this form may be shared with Blue Cross. Your health information which Blue Cross sees will be kept confidential by Blue Cross.*