

Provider Nomination Form For Consumer Choice Option

I. TO BE COMPLETED BY MEMBER

Member's (Patient) Name	Member's (Patient) ID Number	Group Number
Subscriber's Address (City, State, Zip)	Member's (Patient) Date of Birth	
	Member's (Patient) Telephone Number	Member's (Patient) Fax Number
Narrative description of reason for provider nomination: _____		
<p>By signing below, the Subscriber acknowledges that the nominated provider is not a plan In-Network provider and that the provider, therefore, has not been credentialed by the plan credentialing body. Subscriber further acknowledges that he or she alone is responsible for the selection of the nominated provider and that the plan has not undertaken any credentialing or quality assurance measures regarding said provider. The nominated provider will not be credentialed by the plan, nor will the plan undertake to conduct routine quality assurance measures which are used for In-Network providers. The member understands that any and all physicians, hospitals and any others who are not in-network providers must be nominated by the member (patient) and approved by the plan prior to any services being performed by the provider in order for the services to become eligible for reimbursement at in-network benefit levels.</p>		
Subscriber's Signature:	Date: Month _____ Day _____ Year _____	

When this form is completed, please return to:

II. TO BE COMPLETED BY PROVIDER

**BLUE CROSS AND BLUE SHIELD OF GEORGIA TOLL FREE FAX:
P.O. Box 84053, Columbus, GA 31908 (877) 541-1162**

If you have any questions, please call (800) 441-2273.

Name of Nominated Provider		Name of Provider Group (if applicable)	
Provider Georgia License Number	Provider Tax ID Number	Provider's Telephone Number	Provider Fax Number
Provider Address (City, State, Zip)			
<p>By signing below, the provider, or authorized representative, attests that said provider is fully licensed in the state of Georgia to provide the services described above by the patient. Said representative also further states that he/she/it is not a plan network provider and has not been credentialed by the plan. Furthermore, the nominated provider agrees to accept or consider accepting the reimbursement rate established by the plan for specified procedures, agrees not to balance bill the Member designated above, agrees to adhere to the plan's utilization management requirements and other reasonable criteria.</p>			
Signature of Provider or Authorized Representative:		Date: Month _____ Day _____ Year _____	

Diagnosis or Nature of Illness or Injury 1. _____ 3. _____ 2. _____ 4. _____	Sample fees: Plan will provide estimated fees for anticipated services. To ensure prompt and accurate response, including reimbursement rates for provider-listed codes, specific diagnosis codes and procedure codes must be listed for each service. Use attachment if necessary for additional procedures.	<h3 style="margin: 0;">This Section to be Completed by Plan</h3>																																																																																																						
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">Expected Dates of Service</th> <th rowspan="2">Place of Service</th> <th colspan="2">Procedures, Services or Supplies</th> <th rowspan="2">Diag. Code</th> <th rowspan="2">Provider's Estimated Charges</th> <th rowspan="2">Days or Units</th> <th rowspan="2">Allowable Amount</th> <th rowspan="2">Allowed Days / Units</th> <th colspan="2">Covered Benefit?</th> <th colspan="2">Prior Authoriz. Required?</th> </tr> <tr> <th>From</th> <th>To</th> <th>CPT/HCPCS</th> <th>Modifier</th> <th>Yes</th> <th>No</th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr><td>1.</td><td></td><td></td><td></td><td></td><td></td><td style="text-align: center;">\$</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2.</td><td></td><td></td><td></td><td></td><td></td><td style="text-align: center;">\$</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3.</td><td></td><td></td><td></td><td></td><td></td><td style="text-align: center;">\$</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4.</td><td></td><td></td><td></td><td></td><td></td><td style="text-align: center;">\$</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5.</td><td></td><td></td><td></td><td></td><td></td><td style="text-align: center;">\$</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr> <td colspan="8">Hospitals: For an estimate of allowable fees, please submit details as an attachment to this document.</td> <td style="text-align: center;">\$</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Expected Dates of Service		Place of Service	Procedures, Services or Supplies		Diag. Code	Provider's Estimated Charges	Days or Units	Allowable Amount	Allowed Days / Units	Covered Benefit?		Prior Authoriz. Required?		From	To	CPT/HCPCS	Modifier	Yes	No	Yes	No	1.						\$							2.						\$							3.						\$							4.						\$							5.						\$							Hospitals: For an estimate of allowable fees, please submit details as an attachment to this document.								\$					<p>The provision of allowable amounts by the Plan assumes the provider renders services according to the requested procedure codes. It also assumes administration according to the Plan's administrative policies and in accordance with the member's benefits. NOTE: Fees are subject to change. Please verify fees at the time you call for prior authorization of services.</p>			
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Provider's Signature Verifying Acceptance of Fees Specified by Plan _____ (You may sign this before or after the plan has responded payment rates)						Date of Provider Acceptance _____		Signature of Plan Representative _____		Date _____																																																																																														

(see back of form for additional instructions)

Instructions to the Subscriber

- Complete Section 1 of the form—the section entitled “*To Be Completed By Subscriber*”.
- Take the form to the provider you wish to participate as your Consumer Choice Option provider.
- The provider will return the completed form to Blue Cross and Blue Shield of Georgia/HMO Georgia, Inc. Note: Forms submitted without complete provider information will be returned to the member.
- Blue Cross and Blue Shield of Georgia/HMO Georgia will not “credential” any providers you may nominate. You may nominate any qualified provider in the State of Georgia. What this means is that the quality of the provider you nominate has not been screened and that it is solely your responsibility.
- Blue Cross and Blue Shield of Georgia/HMO Georgia will not provide in-network coverage for the provider you are nominating until you have been notified that the application has been approved. This written notice constitutes formal approval of the provider. **We will notify you of approval within 3 days of receiving a complete application.**

Instructions to the Provider:

- This form must be completed in its entirety with all required fields complete.
- Fax the form to Blue Cross and Blue Shield of Georgia/HMO Georgia at (877) 541-1162.
- Blue Cross and Blue Shield of Georgia will notify you of approval to treat the patient within **3 business days of receipt** of the completed form.
- Treatment may not begin until you have received formal notification/authorization from the Plan.
- Contact Customer Service to verify benefits and to receive prior authorization of services **before** beginning treatment.

Listed below is additional information to assist you in obtaining information on how to administer this Blue Cross and Blue Shield of Georgia or HMO Georgia Benefit Plan.

Customer Service: (800) 441-2273

- Eligibility and benefit verification
- Claim status

Medical Management: (800) 441-2273

- Referral authorization (must be initiated by the member’s Primary Care Physician)
- Pre-authorization of medical services, including hospitalizations and outpatient surgeries (contact Medical Management to determine whether services require prior authorization)
- Pre-admission certification
- Emergency hospitalization
- Case management

Provider Relations: (800) 441-2273

- Explanation of plan policies and procedures
- Provider education
- Contractual claim issues
- Provider demographic changes

Claims Department:

Submit claims to: Blue Cross and Blue Shield of Georgia
P.O. Box 84053
Columbus, GA 31908