Anthem Blue Cross - California
Covered Individual (Patient) Responsibility Agreement – Waiver Letter

Contracting Anthem Blue Cross health care professionals/facilities ("Providers") are prohibited from charging Anthem Blue Cross Covered Individuals for any service or supply that is determined by Anthem Blue Cross to be not Medically Necessary, unless the Covered Individuals specifically agrees in advance of the provision of the service or supply to be financially responsible for payment with specific knowledge of Anthem Blue Cross' determination that the service or supply was determined to be not Medically Necessary. This Waiver Letter shall be used by the Provider in such instances and must be separate from any patient payment responsibility information in the hospital admission form. To be effective and valid, this Waiver Letter must be executed prior to the delivery of any service or supply that was determined to be not Medically Necessary.

Covered Individual (Patient) Name: _____ ACIS ID: _____

Subscriber ID: _____ Group No.:_____

Provider: Apria Healthcare CPU: _____

COVERED INDIVIDUAL:

By signing below, I agree to pay Provider for those services or supplies that Anthem Blue Cross determined were not Medically Necessary.

I understand that a Provider may not charge me for a service or supply determined to be not medically necessary unless I have specifically agreed to pay for it in advance and with specific knowledge of Anthem Blue Cross' determination that the services were determined to be not medically necessary. I also understand that the Provider and/or I may appeal any determination that a service or supply is not Medically Necessary by filing a grievance or appeal with Anthem Blue Cross or the Department of Managed Health Care ("DMHC") pursuant to the grievance and appeals procedures described in my Benefit Agreement or Evidence of Coverage ("EOC"). I also understand that I may also have the right to Independent Medical Review through the DMHC, as described in my Benefit Agreement or EOC.

For the services and/or supplies listed below, I understand that I am financially responsible for payment to the Provider, even though they may not be shown on my Explanation of Benefits (EOB) as my financial responsibility.

Date(s) of Service	Description of Service and/or Supply	Approximate Cost	Covered Individual's (Patient's) Responsibility
	See attached Sales Service and Rental Agreement for detailed charges.		

Signature (Covered Individual/Subscriber Signature):	**Date:**