



# Blue Cross Medicare Advantage<sup>SM</sup> Plan

<Utilization Management MAPD>  
<P.O. Box 660694>  
<Dallas, TX 75266-0694>

Member Name: <Member Full Name>  
Member Address: <Member Address>  
Request ID: <XXXXXXXX>

Date: <Month dd, yyyy>

Dear <Member First and Last Name>:

This letter is in response to a request for service(s)/procedure(s) provided by an out-of-network provider. The out-of-network payment provision set forth in your Evidence of Coverage or Summary of Benefits has been waived to allow charges for the requested services to be paid at the in-network payment level. You will still be responsible for charges for any applicable deductibles, coinsurance and/or copayments. Your health plan clinical guidelines and physician review were utilized in determining this payment decision. Benefits for the following service(s)/procedure(s) have been approved as described below.

Member Name: <Member Full Name>  
Date of Birth: <Month-DD-YYYY>  
Member ID: <XXXXXXXXXX>  
Request ID: <XXXXXXXXXX>  
Physician: <Physician Full Name>  
Facility/Provider: <XXXXXXXXXXXXXXXXXXXXXXXXXX>  
Treatment Setting: <XXXXXXXXXXXXXXXXXXXXXXXXXX>  
Onset of Service/Admission Date: <Month-DD-YYYY>  
Total Days/Units of Service: <XXX>  
Service Procedure Code/Description: <XXXXXX-XXXXXXXXXXXXXXXXXXXXXX>

Begin Date	End Date	Days/ Units Approved
------------	----------	----------------------

<MM/DD/YYYY>	<MM/DD/YYYY>	<XXX>
--------------	--------------	-------

Please contact <Blue Cross Medicare Advantage<sup>SM</sup> Plan >at <1-877-774-8592 (Individual)/ 1-877-299-1008 (employer group)/ 1-877-688-1813 (NM DSNP)/1-877-895-6437 (TX DSNP)/ 1-877-774-8592 (OK DSNP)>

prior to the above listed expiration date if an additional review of benefits is needed for further days/units of service. TTY users should call <711>. [If you are calling from April 1 through September 30, alternate technologies \(for example, voicemail\) will be used on the weekends and holidays](#)>.

Blue Cross Medicare Advantage Plan must also be notified if any of the following occur:

- The treatment plan or level of care is changed.
- The ordering physician or facility is changed from that noted above.
- The date of service is changed or cancelled.

Approval through the Blue Cross Medicare Advantage Plan Health Care Management Department is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations, and exclusions of your Evidence of Coverage and/or Summary of Benefits. For questions regarding benefits, please contact the Customer Service unit at the telephone number listed on the back of your health insurance card. You remain responsible for any out-of-pocket requirements, including, but not limited to, coinsurance, copayments, deductibles and/or non-covered charges.

Out-of-network/non- contracted providers are under no obligation to treat Blue Cross Medicare Advantage Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost- sharing that applies to out-of-network services.

As always, the decision whether to receive the proposed service/procedure remains between you and your health care providers. Coverage, benefit, and payment decisions do not constitute treatment decisions.

A copy of this information has also been sent to the provider/facility and physician.

Sincerely,

<[Blue Cross Medicare Advantage Plan](#)>

cc:     <[Attending Full Name](#)>  
          <[Attending Address](#)>  
          <[Attending City, Attending State Attending Zip Code](#)>

<Facility Name>  
<Facility Address>  
<Facility City, Facility State Facility Zip Code>

<Primary Care Physician Full Name>  
<Primary Care Physician Address>  
<Primary Care Physician, Primary Care Physician State Primary Care Zip Code>

<HMO plan in New Mexico, HMO and HMO-POS plans in Illinois, and PPO plans in Illinois, Montana, and New Mexico are provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HMO plan in Illinois provided by Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC). HMO Special Needs Plan and PPO Special Needs Plan in New Mexico provided by HCSC. HMO, PPO, and Dual Care HMO Special Needs plans in Texas provided by HCSC Insurance Services Company (HISC). PPO plan in New Mexico provided by HISC. HMO and PPO plans in Texas provided by GHS Insurance Company (GHSIC). All HMO and PPO employer/union group plans provided by HCSC. HMO plan in Oklahoma provided by GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO (BlueLincs). HMO Special Needs Plan and PPO plans in Oklahoma provided by GHS Insurance Company (GHSIC). HCSC, ILBCBSIC, HISC, GHSIC, and BlueLincs are Independent Licensees of the Blue Cross and Blue Shield Association. ILBCBSIC, GHSIC and BlueLincs are Medicare Advantage organizations with a Medicare contract. HCSC is a Medicare Advantage organization with a Medicare contract and a contract with the New Mexico Medicaid program. GHSIC is a Medicare Advantage organization with a Medicare contract and a contract with the Oklahoma Medicaid program. HISC is a Medicare Advantage organization with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in these plans depends on contract renewal.>