Blue Cross Blue Shield of North Dakota is an Independent licensee of the Blue Cross & Blue Shield Association

Advance Member Notice

Completion of this form acknowledges that the member is fully responsible for all charges associated with the procedure/item/service requested below because the procedure/item/service may not be medically necessary and/or is not a covered benefit. This notice is not required for the member to receive medically appropriate and necessary covered services.

Patient E# or MRN# _____

TESTS INDICATED BELOW MAY BE CONSIDERED "NON-COVERED" BY YOUR HEALTH PLAN POLICY, PLEASE CHECK YOUR POLICY FOR COVERAGE					
TESTING DESCRIPTION	SELECT TEST (X) REQUIRED	ORDER CODE	CPT CODES INITIAL TESTING (ALWAYS BILLED)	CPT CODES (BILLED IN ADDITION)	ESTIMATED CHARGE TO PATIENT INSURANCE
Chromosome Microarray, Congenital		LBOR0208	81229	N/A	**$3,437**
Chromosome Analysis, Congenital Disorders		LBOR0216	88230 AND 88291	88261 or 88262 or 88263	**$439 - $1,222**
Chromosome Microarray (CMA) Familial Testing, FISH		LBOR0217	88271x2, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and where applicable 88271x1 up to x14	**$565 - $1,599**
Williams Syndrome, 7q11.23 Deletion, FISH		LBOR0219	88271x2, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and where applicable 88271x1 up to x14	**$565 - $1,599**
Sex-Determining Region Y, Yp11.3 Deletion, FISH and Chromosome Analysis, Congenital		LBOR0220	88271x2, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and one of 88261 or 88262 or 88263 and where applicable 88271x1 up to x14	**$565 - $2,382**
Known 45,X, Mosaicism Reflex Analysis, FISH		LBOR0221	88271x2, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and where applicable 88271x1 up to x14	**$565 - $1,599**
22q11.2 Deletion/Duplication, FISH		LBOR0190	88271x2, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and where applicable 88271x1 up to x14	**$565 - $1,599**
Aneuploidy Detection FISH (13, 18, 21, X, Y)		LBOR0218	88271x5, 88230 AND 88291	88272 or 88273 or 88274 or 88275 and where applicable 88271x1 up to x11	**$754 - $1,599**
Chromosome Microarray with 5-Cell Chromosome Analysis Reflex, Congenital		LBOR0239	81229, 88230 AND 88291	88261 or 88262 or 88263	**$3,876 - $4,659**

FOR THE PATIENT

I acknowledge that I am voluntarily signing this statement, and that it is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) for any procedure/item/service listed above that is denied as non-covered by Blue Cross Blue Shield of North Dakota and will pay the provider as charged. I also understand that it is my choice to have the services provided at a future date and time by this provider.

Patient Name _____

Benefit Plan Number _____

Patient Signature _____ Date _____

FOR THE PROVIDER

As a participating Blue Cross Blue Shield of North Dakota provider, I certify that I have informed the above patient regarding the Advance Member Notice. **I acknowledge that BCBSND medical policy, BCBSND Participation Agreement provisions, and any other policies promulgated by BCBSND, including any resulting decisions on financial responsibility, supersede this Advance Member Notice.**

Provider Name _____

Provider Signature _____ Date _____

When this form is filled out to completion and signed by patient & provider please fax to: 1-605-312-8964