UnitedHealthcare Oxford

Member Advance Notice Form for the Involvement of a Nonparticipating Provider

Your physician or other healthcare professional has decided to involve a nonparticipating physician, facility or other health care provider in your care. In order to assist you in making informed decisions regarding your health care, we ask that you sign this form to indicate you have had a discussion with your physician or other health care professional about your option to utilize a participating provider and you have agreed to receive services from a nonparticipating provider despite the potential increased out-of-pocket costs associated with that decision.[1]

Please note that if you have out-of-network benefits under the terms of your benefit plan, you may utilize those benefits to receive services from a nonparticipating provider. However, we believe it is important you understand that you may have higher out-of-pocket costs when using a nonparticipating provider based on your benefit plan. Please also note that if you do not have out-of-network benefits under the terms of your benefit plan and you receive services from a nonparticipating provider, you may be responsible for the entire cost of the services.

If you have questions or would like to find a participating provider who can perform the services you require, please ask your physician or other health care professional to arrange for the use of a participating provider. You can confirm the participation status of providers by calling Customer Care at the phone number on your health plan ID card. You may also log in to our website, oxfordhealth.com, to search the online provider directory for a participating provider in your area.

To be completed by the member's physician or other health care professional:

Physician/Health Care Professional Name	
Physician/Health Care Professional Tax ID #	
Member Name	
Member ID #	
Nonparticipating Physician/Facility/ Health Care Provider Name	
Type of Service Nonparticipating Provider will Render	
Date of Service	
Reason for Involving a Nonparticipating Provider	

To be completed by the member or the member's legal guardian:

I am aware that the physician, facility or other health care provider listed above will be involved in my care on the date of service listed above and I understand that this health care provider is not a participating provider in the Oxford network. **I was provided** and declined the opportunity to select a participating provider to provide the health care services indicated above and am voluntarily choosing to obtain services from a nonparticipating provider. **I am aware that I may be responsible** for any additional costs resulting from my use of a nonparticipating provider, if provided in my benefit plan. I understand that nonparticipating providers are generally prohibited from waiving member cost share amounts such as copayments, deductibles and coinsurance.
Signature of Member, Parent (if the member is under age 18) or Legal Guardian:
Printed Name of Member, Parent (if the member is under age 18) or Legal Guardian:
Date:
Telephone Number:

[1] Participating health care providers are required to keep a copy of this completed form on file. **Members may request a copy of this completed form from their participating provider.**