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# _____

PROCEDURE/ITEM/SERVICE (PLEASE CHECK TEST(S) THAT APPLY BELOW)**	**CPT/HCPCS CODE**	**(ESTIMATED) BILLED PROFESSIONAL CHARGE**
____**PHARMACOGENETIC PANEL:** *Includes (CYP2C9, CYP2C CLUSTER, CYP2C19, CYP2D6, CYP3A5, CYP4F2, IFNL3, VKORC1, SLCO1B1, TPMT AND DPYD)*	81479	$199.00 THIS PANEL IS NEVER BILLED TO INSURANCE, IT IS DIRECT PAY ONLY
____ **CYP2C19** (CPT 81225) ____ **SLCO1B1** (CPT 81328) ____ **CYP2D6** (CPT 81226) ____ **DPYD** (CPT 81232) ____ **CYP3A5** (CPT 81231) ____ **TPMT** (CPT 81335) ____ **CYP4F2** (CPT 81479) ____ **IFNL3** (CPT 81283) ____ **CYP2C9 AND VKORC1** (CPTs 81227 AND 81355)	SEE CPT CODES INDICATED WITH EACH TEST IN THE BOX TO THE LEFT	$199.00 (IF A FULL PANEL IS NOT WARRANTED, SINGLE GENES CAN BE ORDERED. UP TO 9 SINGLE GENES CAN BE ORDERED AND BILLED TO INSURANCE AS THE SAME PRICE AS THE PANEL)

** CYP2C cluster is not available as single gene (requires combination with other genes for clinical relevance)

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)312-4132