Consent for Referral to an Out-of-Network Provider

PROVIDER INSTRUCTIONS

Complete this form ONLY for patients enrolled in Braven Health SM plans that include out-of-network benefits [i.e., Braven Medicare Choice (PPO), Braven Medicare Freedom (PPO), Braven Medicare Group (PPO) or Braven Medicare Access Group (HMO-POS)].

DO NOT use this form for patients enrolled in the Braven Medicare Plus (HMO) plan which does not include out-of-network benefits.

When treating a patient enrolled in a Braven Health plan that includes out-of-network benefits, participating doctors and other health care professionals are **required** to:

1 **Complete this form:**
- Before referring a patient to an out-of-network provider (including but not limited to doctors, facilities, other health care providers, clinical lab patient service centers, specialty pharmacies, home infusion providers, etc.)
- Before sending a patient's laboratory sample to an out-of-network clinical laboratory
- Before you use an out-of-network doctor (e.g., an anesthesiologist, co-surgeon or assistant atsurgery) to perform a service.

2 **Have a discussion with your patient** (or his/her parent, guardian or personal representative) **before:**
- using an out-of-network provider to advise that:
- An out-of-network provider will be involved in your patient'scare
- Claims for services provided by out-of-network providers will be processed at your patient's out-of-network level of benefits
- Your patient will be responsible for his/her out-of-network cost-sharing amounts (copayments, deductible and coinsurance amounts, as applicable).

3 **Have your patient** (or his/her personal representative) **initial/sign** this form to attest that the patient:
- Is aware of and agrees to the use of an out-of-network provider
- Understands the financial impact of the decision to use an out-of-network provider

4 **Retain the original completed form** in the patient's medical record and provide a copy to your patient.

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FOR PATIENT REVIEW:
HOW WILL USING AN OUT-OF-NETWORK PROVIDER IMPACT ME?

We encourage you to use in-network providers (including but not limited to, doctors, facilities, other health care providers, clinical lab patient service centers, specialty pharmacies, home infusion providers, etc.) to help you maximizeyour benefits and save you money. If you make the choice to use an out-of-network doctor, facility or other health care provider, it's important that you understand the financial impact of this decision.

When you use your out-of-network benefits, you are responsible for all appropriate and applicable cost-sharing amounts (copayments, deductible and coinsurance amounts).

- If your cost sharing is a copayment (a set amount of dollars, for example, $15), then you pay only that amount for covered services from a provider.
    - Please note that you will generally have higher copayments when you obtain care from out-of-network providers.
    - If your cost sharing includes deductible and coinsurance, then you will not pay more than those amounts as applicable. However, your deductible and coinsurance amounts will depend on which typeof provider you see:
- If you receive covered services from a Braven Health participating provider, you pay the in-network coinsurance percentage multiplied by our contracted allowance for that service (as determined in the contract between the provider and us).
    - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate forparticipating providers.
    - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.

As a Braven Health plan member, you only have to pay your cost-sharing amount when you receive services covered by your Braven Health Plan.

Providers are not allowed to add additional separate charges, called "balance billing." If you believe a provider has "balance billed" you, please call the Member Services phonenumber on the back of your Braven Health ID card.

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THIS PAGE TO BE COMPLETED BY:
THE REFERRING DOCTOR/OTHER HEALTH CARE PROFESSIONAL

The referring doctor/other health care professional must complete this section and hold a discussion with his or her patient prior to out-of-network services being provided.

Name of Referring Practitioner ____________________

NPI ____________________

Phone ____________________ Email ____________________

Patient Name____________________ Patient DOB ____________________

Subscriber Name____________________ Subscriber ID # ____________________

Name of OON provider being referred to ____________________

Provider Type ____________________

Address ____________________

Service to be rendered (e.g. labs, dialysis, anesthesia) ____________________

Reason for using an out-of-network provider:

- ☐ Provider specialty is not available within the participating network for my patient
- ☐ Member preference/convenience
- ☐ Provider preference
- ☐ Other (*please explain*) ____________________

I, the referring practitioner, recommended/offered my patient the opportunity to use an in-network provider.

- ☐ Yes
- ☐ No

I, the referring practitioner, understand that using an out-of-network provider increases patient financial responsibility.

- ☐ Yes
- ☐ No

I, the referring practitioner, have a financial interest in the referred-to out-of-network provider noted above.

- ☐ Yes
- ☐ No

I, the referring practitioner, receive compensation from the referred-to out-of-network provider noted above.

- ☐ Yes
- ☐ No

THIS PAGE TO BE COMPLETED BY:
THE PATIENT (OR THE PATIENT'S PERSONAL REPRESENTATIVE):

After a discussion with your referring doctor/other health care professional about the details completed above (and before out-of-network services are provided), please review and initial thestatements and sign below.

By initialing to the each statement and signing and dating below, I, the member (or his/her designatedpersonal representative), attest that I am aware and understand the following:

________ My referring doctor/other health care professional completed the details on this form andspoke to me about using the out-of-network doctor, facility or other health care provider listed above.

________ The doctor, facility or other health care provider to be involved in my care **is not** in-networkand/or **does not** participate with my Braven Health insurance plan.

________ My referring doctor/other health care professional offered me the opportunity to use anin-network doctor, facility or other health care provider, but I declined this offer.

________ Claims from an out-of-network doctor, facility or other health care provider will be processedat my out-of-network level of benefits.

________ I will be responsible for all out-of-network cost-sharing amounts (applicable copayments,deductible and/or coinsurance).

________ If services *were* provided by an in-network doctor, facility or other health care provider, that my in-network level of benefits would apply and that I would *not* be billed for out-of- network cost-sharing amounts.

________ LabCorp® and Quest Diagnostics™ are Horizon's preferred clinical laboratory providers. Tests/services rendered by LabCorp or Quest will have the lowest member responsibility and may have zero member responsibility.

________ Horizon BCBSNJ may contact me in the future to ask about amounts I paid to theout-of-network doctor, facility or other health care provider in question.

____ ______________

Signature of Patient (or the patient's designated personal representative) Date

Braven Health

Notice of Nondiscrimination

Braven Health complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Braven Health provides free aids and services to people with disabilities (e.g. qualified language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

Contacting Member Services
Call Member Services at **1-833-272-8360** (TTY **711**) **or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues.**

Filing a Section 1557 Grievance
If you believe that Braven Health has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. Braven Health's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to:

Braven Health
Civil Rights Coordinator – PP-16F
PO Box 420
Newark, NJ 07101

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, online at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail at **U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201** or by phone at **1-800-368-1019** or **1-800-537-7697** (TDD). OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Language assistance
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-833-272-8360** (TTY **711**).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-833-272-8360**（TTY 711）.
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-833-272-8360 (TTY 711)번으로 전화해 주십시오.
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-833-272-8360** (TTY **711**).
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-833-272-8360** (TTY **711**).
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-833-272-8360** (TTY **711**).
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-833-272-8360** (TTY **711**).
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-833-272-8360** (رقم هاتف الصم والبكم 711).
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-833-272-8360** (TTY **711**).
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-833-272-8360** (телетайп **711**).
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-833-272-8360** (TTY **711**).
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-833-272-8360** (TTY **711**) पर कॉल करें।
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-833-272-8360** (TTY **711**).
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-833-272-8360** (ATS **711**).
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-833-272-8360 (TTY **711**).