Northern Plains
Laboratory

To all providers and laboratory staff:

Blue Cross Blue Shield has begun to follow Medicare guidelines for some laboratory tests that they say are not medically necessary based on diagnosis. The high volume tests that are mainly affected are the Vitamin D assay and the Covid Antibody test. Northern Plains Laboratory has not been able to bill the patients back for these denied tests as Blue Cross Blue Shield does not hold the patient liable. Blue Cross Blue Shield will hold the patient responsible if they are notified that the patient has signed an Advance Member Notice. A copy of this notice is attached to this correspondence. If Northern Plains Laboratory is billing BCBS, we request that you have the patient and the provider complete this form and forward it to Northern Plains Laboratory with the specimen. A copy of the Advance Member Notice is also available on the Northern Plains Laboratory website.

Please note:

For Covid Antibody testing: An Advance Member Notice must be completed for all BCBS patients. The estimated cost is $62.00.

For VitD testing: If the patient is known Vitamin D deficient and the diagnosis E55.9 is applied to the order, then an Advance Member Notice is not required. Please complete an Advance Member Notice for any other diagnosis. The estimated cost is $119.00.

Please direct any questions to the Northern Plains Laboratory billing office.

Ph: 701-222-2480 or 1-800-659-0395

Advance Member Notice

Migrated Members

Completion of this form acknowledges that the member is fully responsible for all charges associated with the professional or institutional 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.

Beginning July 1, 2018, and on group anniversary thereafter, this form can be used for members who have migrated to BCBSND's new claims processing system.

Procedure/Item/Service	(Estimated) Billed Charge

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