UnitedHealthcare®

Member Advance Notice Form for the Involvement of a Nonparticipating Provider

Your physician or other health care professional has decided to involve a non-participating 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 non-participating 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 non-participating provider. However, UnitedHealthcare believes it is important you understand that you may have higher out-of-pocket costs when using a non-participating 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 non-participating provider, you may be responsible for the entire cost of the services.

If you have questions or would like to find a participating provider that 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 contacting UnitedHealthcare Customer Care at the telephone number on the back of your health plan ID card. You may also log onto myuhc.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	Andrew D. Pearle, MD
Physician/Health Care Professional Tax ID #	263381739
Member Name	
Member ID #	
Non-Participating Physician/Facility/ Healthcare Provider Name	PA
Type of Service Non-Participating Provider will Render (e.g. Lab, Dialysis)	MD out-of-office or Assistant needed in the Operating Room
Date of Service	Effective from date signed.NO EXPIRATION DATE
Reason for Involving a Non-Participating 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 UnitedHealthcare's 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 non-participating provider. **I am aware that I may be responsible** for any additional costs resulting from my use of a non-participating provider, if provided in my benefit plan. **I understand** that non-participating providers are generally prohibited from waiving member cost share amounts such as co-payments, deductibles and coinsurance.

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Signature of Member, Parent (if the member is under age 18) or Legal Guardian

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Printed Name of Member, Parent (if the member is under age 18) or Legal Guardian

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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.