KJ Kids
Kjartan D. Armann, MD
Alison Chase, DO
Infant, Child and Adolescent Medicine

2516 Samaritan Dr., Suite J
San Jose, CA 95124
Phone: (408) 356-0578
Fax: (408) 356-3986
www.kjkidmd.com

Member Advance Notice Form for the Involvement of a Nonparticipating Provider

Your physician may decide 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.

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, your insurance 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, contact your Insurance Customer Care at the telephone number on the back of your health plan ID card. You may also log onto your insurance's web site to search the online provider directory for a participating provider in your area.

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

I am aware that the physician, facility or other health care provider involved in my care may not be a participating provider in my insurance network. **I was provided** with the information above regarding choosing a non-participating provider to provide my Health Care Service and I voluntarily choose 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.

_____
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