UnitedHealthcare Oxford

Member Advance Notice Form for the Involvement of a Nonparticipating Provider

Your physician or other healthcare professional has decided to involve a nonparticipating physician, facility or other healthcare provider in your care. In order to assist you in making informed decisions regarding your healthcare, we ask that you sign this form to indicate you have had a discussion with your physician or other healthcare professional about your option to utilize a participating provider and you have agreed to receive services from a nonparticipating provider.

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 nonparticipating provider. However, we believe 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 nonparticipating provider, you may be responsible for the entire cost of the services.

If you have questions or would like to find a participating provider who can perform the services you require, please ask your physician or other healthcare professional to arrange for the use of a participating provider. You can confirm the participation status of providers by contacting Customer Service at the telephone number on the back of your health plan ID card. You may also log onto oxfordhealth.com to search the online provider directory for a participating provider in your area.

To be completed by the member's physician or other healthcare professional:

Physician/Healthcare Professional Name	
Physician/Healthcare Professional Tax ID #	
Member Name	
Member ID #	
Nonparticipating Physician/Facility/ Healthcare Provider Name	
Type of Service Nonparticipating Provider will Render	
Date of Service	
Reason for Involving a Nonparticipating Provider	

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

I am aware that the physician, facility or other healthcare provider listed above will be involved in my care on the date of service listed above and I understand that this healthcare provider is not a participating provider in the Oxford network. **I was provided** and declined the opportunity to select a participating provider to provide the healthcare services indicated above and am voluntarily choosing to obtain services from a nonparticipating provider. **I am aware that I may be responsible** for any additional costs resulting from my use of a nonparticipating provider, if provided in my benefit plan**. I understand** that nonparticipating providers are generally prohibited from waiving member cost share amounts such as copayments, 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:
Telephone Number:

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