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Conejo Los Robles Anesthesiology Medical Group

Notice for all Blue Cross and Blue Shield Patients Requesting Anesthesia Care for Endoscopic Procedures at

Los Robles Surgicenter

Blue Cross and Blue Shield have determined that the routine services of an anesthesiologist for average risk patients undergoing upper and lower gastrointestinal endoscopic procedures is not medically necessary, and therefore Blue Cross and Blue Shield will usually not pay for these services. CLRAMG is a contracted provider with Blue Cross and Blue Shield and as such, we must honor the EOB (Explanation of Benefits) if we submit a claim on your behalf. In order to provide our services, we need you to sign this waiver, acknowledging that in the event that your insurance company does not approve the claim, you agree to pay us this discounted amount. This discounted rate is for patients paying by cash, check or eCheck. For patients paying by eCheck, Please call (805) 578-8300, or visit WWW.CLRAMG.COM.

$295 for a Colonoscopy or Upper Endoscopy
$420 for a combined Colonoscopy/Upper Endoscopy

For patients paying by Visa, Mastercard, or Discover at the time of service, Please call (805) 578-8300, or visit WWW.CLRAMG.COM.

$310 for a Colonoscopy or Upper Endoscopy
$440 for a combined Colonoscopy/Upper Endoscopy

Please bring this form with the card authorization number or a copy of your payment receipt and give it to your anesthesiologist.

Your signature below indicates that you understand that your insurance company may not allow payment for anesthesia services for your procedure and you agree to pay the above sum for these services.

If you desire CLRAMG to bill your insurance despite the reasonable likelihood that they will deny the claim, please check the appropriate box below. In the event that your insurance company approves your anesthetic, the fee that you have paid will be credited toward the payment spelled out on your EOB (Explanation of Benefits). This may result in a refund to you or an additional fee. Regardless of whether CLRAMG bills your insurance, the above payment is due prior to your procedure.

Please check the box below to let us know if you'd like us to bill your insurance company.

D Do not send a claim to my insurance company. My payment represents a cash discounted payment in full.

D Please send a claim to my insurance company. I understand this may result in a higher payment due.

Signature — — — — — — — — — — — — — —

Name_____

Date of Service_____

Credit Authorization Number_____

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1633 Erringer Road Suite 101 Simi Valley, CA 93065
p: 805.578.8300 • f: 805.578.8950 • www.mtbchealth.com