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.

To pay by check, please write check to "CLRAMG", and give it to your anesthesiologist. They will provide you with a receipt.

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

To pay by credit card Please call (503)372-8134

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

Your signature below indicates that you understand that your insurance company may not cover 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 paid will be credited toward the claim as 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.

Please check the applicable box(es) below.

☐ No Prepay required. Insurance will be billed.

☐ I paid in advance. Authorization number _____

☐ I brought: ☐ a Check # _____ Amount: $_____ ☐ Cash Amount: $_____

Received by Dr. _____. This serves as your receipt.

☐ I will pay after the procedure. I understand that in order to take advantage of the discounted rate, payment is due within two business days by credit card. (Instructions written above)

☐ **Do not send a claim to my insurance company**. My payment represents payment in full.

☐ **Send a claim to my insurance company**. I understand this may result in a higher payment due.

Signature _____

Name _____

Date of Service _____