

## **NOTIFICATION OF NON-FILED SERVICES**

Date

Monies Due

You have opted to pay for the services outlined below in lieu of having them filed on a claim through your health insurance carrier, Blue Cross and Blue Shield of Alabama. You are expected to pay for these services in full.

Section I: Patient Information							
First Name		Middle Initial Last Name		st Name			
Address		City			State	Zip	
Home Phone Cell Phone		Email		ail			
Section 2: Non-Filed Services  Services  Patient		anaturo*			Date Monies Due		
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Services Patient		gnature*			te	Monies Due	
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Services Patient		ignature*			Date Monies Due		
Services Patient		ignature*			te	Monies Due	
Services	Patient Sig	gnature*		Da	te	Monies Due	
Services Patient S		gnature*			Date Monies Due		

Patient Signature\*

Services

<sup>\*</sup>I have read your policy and agree to pay for the services outlined above which I do not want filed on a claim through Blue Cross.