BlueCross BlueShield of Alabama

NOTIFICATION OF NON-FILED SERVICES

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		
Address	City		State	Zip
Home Phone	Cell Phone	Email		

Section 2: Non-Filed Services

Services	Patient Signature*	Date	Monies Due
Services	Patient Signature*	Date	Monies Due
Services	Patient Signature*	Date	Monies Due
Services	Patient Signature*	Date	Monies Due
Services	Patient Signature*	Date	Monies Due
Services	Patient Signature*	Date	Monies Due
Services	Patient Signature*	Date	Monies Due
Services	Patient Signature*	Date	Monies Due
Services	Patient Signature*	Date	Monies Due
Services	Patient Signature*	Date	Monies Due

*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.