Bay Area Anesthesia
Anesthesia For Children & Adults

TRICARE®

TRICARE BENEFICIARY LIABILITY FORM
(Waiver of Balanced Billing Protection For Services Rendered By "Non-Authorized" Provider)

This is to fully inform the TRICARE beneficiary of the following:

- **Dr. Thomas Lenhart/Bay Area Anesthesia is a "*Non-Authorized*" TRICARE provider.**
- **Dr. Thomas Lenhart/Bay Area Anesthesia does *NOT* agree to participate in any TRICARE claim(s).**
- **Dr. Thomas Lenhart/Bay Area Anesthesia does *NOT* accept the TRICARE allowable charges or non-allowable charges as partial-payment or payment-in-full for anesthesia services rendered.**

I am hereby requesting that Dr. Thomas Lenhart/Bay Area Anesthesia provide the following anesthesia services to _____/_____.

(Patient Name) (Beneficiary Name)

I, _____, the TRICARE beneficiary, waive my balance-billing protection and hereby agree to pay the full-billed charge(s) for the following service(s) regardless of the fact that the TRICARE program consider it a covered or non-covered service:

Date: _____ Service (Code): _____ Units: _____ [Estimated/Actual] Billed Charge: _____
Date: _____ Service (Code): _____ Units: _____ [Estimated/Actual] Billed Charge: _____
Date: _____ Service (Code): _____ Units: _____ [Estimated/Actual] Billed Charge: _____
Date: _____ Service (Code): _____ Units: _____ [Estimated/Actual] Billed Charge: _____
Date: _____ Service (Code): _____ Units: _____ [Estimated/Actual] Billed Charge: _____
Date: _____ Service (Code): _____ Units: _____ [Estimated/Actual] Billed Charge: _____
Date: _____ Service (Code): _____ Units: _____ [Estimated/Actual] Billed Charge: _____
Date: _____ Service (Code): _____ Units: _____ [Estimated/Actual] Billed Charge: _____

TOTAL [Estimated/Actual] BILLED CHARGES: _____

I, _____, the TRICARE beneficiary, acknowledge that the above Non-Network/"Non-Authorized" TRICARE provider is billing above the 115 percent CHAMPUS Maximum Allowable Charge (CMAC) and that I, the beneficiary, will not receive the benefit of the TRICARE Balance Billing Limitation (defined below), which otherwise might apply to me.

TRICARE Balance Billing Policy: *Balance billing is the practice of a provider billing a beneficiary the difference between the TRICARE allowed amount and the billed charges on a claim. Participating providers and network providers may not collect from all sources an amount, which exceeds the TRICARE allowed amount. Non-Authorized providers may not collect an amount, which exceeds the balance-billing limit (115% of the allowed charge). If the billed charge is less than the balance-billing limit, then the billed charge is the maximum amount that can be collected by the nonparticipating provider.*

I, _____, the TRICARE beneficiary, feel strongly about the Non-Network/"Non-Authorized" TRICARE provider, Dr. Thomas Lenhart/Bay Area Anesthesia, rendering anesthesia services and am willing to pay the additional money. I fully understand that I am fully responsible for the full-billed charges for services rendered. Accordingly, **I agree that I will be personally responsible for the payment IN FULL of the billed charges for these services on the day of service and that neither the beneficiary nor the provider will submit a claim for the services to TRICARE** thus I, the beneficiary, agree in writing, to exempt Dr. Thomas Lenhart/Bay Area Anesthesia from the Balance Billing rules for this specific episode of care AND waive all rights regarding Balance Billing protection. I, the beneficiary, acknowledge that I am signing this statement voluntarily, and that it is not being signed under duress on the day of service or after the services have already been provided.

Date: _____ **Signature (Patient/Guardian): _____**
Print Name (Patient/Guardian): _____

Date: _____ **Provider Signature: _____**
Print Provider Name: _____

Privacy Act Statement:
In view of the fact that personal information is being requested from you, notice is hereby given as required by the Privacy Act of 1974. The information is requested and maintained under the authority of Chapter 55, Title 10, United States Code, Section 3101, Title 44, United States Code, and 41 Code of Federal Regulations 101-1100 et seq. The information is requested to establish or update information to control or process claims for payment. Routinely, the information will be used to determine eligibility for TRICARE benefits, review and approve medical care as TRICARE benefits, and to determine reasonable charges/costs of care to be cost-shared under TRICARE. Disclosure of the information is voluntary; however, failure to provide the information may result in denial of benefits.