Sarasota Anesthesiologists, P.A.
1261 South Tamiami Trail
Sarasota, Florida 34239
941-366-2360

Notice of Non-Participation in the Blue Cross Blue Shield Network

Sarasota Anesthesiologists is the sole provider of anesthesia at Sarasota Memorial Hospital. While the hospital is an in-network provider for Blue Cross Blue Shield ("BCBS"), Sarasota Anesthesiologists is currently a non-participating provider.

BCBS reimburses Sarasota Anesthesiologists at rates less than half those at the only other hospital in town, and far less than the average managed care rate in Florida. Despite Sarasota Anesthesiologists' efforts to renew an agreement with BCBS, we were unable to arrive at what we feel is a fair agreement.

To help ease patient concerns during this time, Sarasota Anesthesiologists will accept BCBS out-of- network rates, and will not balance bill any patient. However, the patient will still be responsible for any co-payment and co-insurance specified in their benefit plan.

We will make every attempt to prevent you from paying more out-of-pocket due to our non-participating status with BCBS and Sarasota Anesthesiologists will work with any patient whose out-of-pocket payment is substantially increased to make their payment more in line with their in-network payment rate. To help you avoid overpaying, we may need to appeal BCBS's determination of your benefits. To do so, we will need you to execute an **Authorization of Representation Form** and an **Assignment of Benefits Form** to authorize Sarasota Anesthesiologists to receive payment from BCBS. Please contact our office if you have not received these forms, or if you have questions about this process.

We apologize for any inconvenience or concerns that you may have because of our non-participating status with BCBS, but we felt we were left with no alternative as we work to reach a fair agreement. All the more than 80 members of our organization look forward to continuing participation in your care. If you have any questions, please call our office at **941-366-2360** or e-mail at office@sarasotaanesthesia.com

Sincerely,

Leonard Mindlin, MD
President, Sarasota Anesthesiologists, P.A.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

HMO & PPO Appeals
PO Box 44197
Jacksonville, FL
32231-4197

APPOINTMENT OF REPRESENTATIVE FORM

MEMBER NAME _____ POLICYHOLDER'S MEMBER ID NUMBER _____

APPOINTMENT OF REPRESENTATIVE

I appoint _____ (name of representative), a natural person, to act as my representative in connection with my appeal.

As my representative and in my stead, I authorize the above-named individual (for the specific and exclusive purpose of representing my interests and exclusively and only for this appeal) to make or give any request or notice on my behalf; present or elicit evidence supporting my appeal; obtain information necessary for this appeal; including, without limitation, the release of past, present, or future: HIV test results, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and any other information regarding my medical diagnoses, treatments and/or conditions; and to receive any notice in connection with my pending appeal or asserted rights.

Please enter a specific description of the health care service with respect to which this appeal is being submitted (e. g. description of service that was denied, the date of service and claim number, specific procedure and/or diagnosis codes (if applicable):

_____

(Attach additional sheets if more space is needed)

SIGNATURE (member, parent, or guardian) _____ **ADDRESS** _____

TELEPHONE NUMBER (area code) _____ **DATE** _____

ACCEPTANCE OF APPOINTMENT

I, _____, a natural person, hereby accept the above appointment. I understand that I cannot assign this appointment to another individual and that any attempt to do so is invalid. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not as a current or former officer or employee of the United States, disqualified as acting as the claimant's representative; that I will not charge or receive any fee for the representation unless: 1) it has been authorized in accordance with the laws and regulations and 2) I have fully disclosed, to the member, parent or guardian above, the amount and method of remuneration/compensation that I have received or expect to receive in connection with my representation of the member.

I am a/an _____

(Attorney, union representative, relative, etc.)

SIGNATURE (Representative) _____ **ADDRESS** _____

TELEPHONE NUMBER (area code) _____ **DATE** _____

"Si desea este documento en Español, llame al 1-877-352-2583"

PATIENT BILLING INFORMATION

Anesthesia is commonly a covered component of your surgery. As a courtesy, the bill/claim for anesthesia services will be filed directly to the primary insurer. We will accepted the assignment of benefits(below) and your insurer should send the payment directly to our address. If we have a secondary insurer on file, we may file a claim for the amount not paid by your primary insurer. If no secondary insurance was provided, we may send you a statement for the co-pay due as determined by your insurer.

In the event that _____. is not a participating provider with your plan, we will work directly with your insurer(s). The amount you may owe will be within the applicable "Reasonable and Customary" benefit rate limits. We often negotiate with insurers to minimize out-of-pocket costs due to our out-of-network status. In the event that your balance due for services differs from your explanation of benefits ("EOB") based on an adjustment by us, please contact your insurer(s) to alert them of the adjustment. It is your responsibility to contact the insurer(s) to report any adjustments applied to the patient portion due. This allows them to update their records to reflect any differences in your out-of-network deductible, out-of-pocket expenses and catastrophic cap for the benefit year.

If your insurance carrier sends payment directly to you, please contact us immediately so we may notate your account to avoid any unnecessary requests for payment. Once you reach us, we will ask that you deposit the check into your account and write a personal check for the amount of the payment you received. You will need to make the check out to _____ and mail the check to the address above. We will also require a copy of the original EOB you received when mailing. If you have any questions or concerns, please contact our billing company at **1-999-999-9999**. You may also contact our Administrative Office at **1-999-999-9999 extension 9.** Please ask any questions that you may have so the content of this letter is understood at the time of service.

You will receive an EOB from your carrier. Until a statement is received by you from _____, please do not make any payments to us until you are notified in writing.

ASSIGNMENT OF BENEFITS

_____
Post Office Box XXX
Sarasota, FL 34243

I _____ (Print Name) with insurance benefits through _____ (Employer Name if applicable) _____ (Medicare, Medicaid, Individual or Group Plan) hereby authorize benefits to be assigned to _____ ("Provider"), for healthcare services rendered to me, or to the patient for whom I am a Guardian, if applicable, by Provider, pursuant to Florida Section 627 and all other applicable state and federal laws. I certify that the information identified herein is true and accurate as of the date of service and that I am responsible for keeping it updated. I am aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I understand that my insurer may not pay 100% of the medical claim, and I may be responsible for any amounts not payable by my insurer, including any portion paid and not applied to in-network benefits for any out-of-network services.

I authorize Provider to submit claims on my behalf to the insurance company providing my benefits, under any applicable plans held in my name or for my benefit. I hereby instruct and direct my Insurer to pay all plan benefits directly to Provider for all services rendered. I understand under applicable state and federal law that I have the right and authority to direct where payment for services rendered be sent. If my current policy prohibits direct payment to the provider of service, I hereby instruct my Insurer to issue a check directly to Provider, mailed to the address listed above, or otherwise designated by Provider for payment. Said check shall be made payable to me as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse "for deposit only," and to deposit and apply all proceeds toward payment of my account. This authorization includes any and all rights permissible, including all rights of appeal, disclosures, administrative reviews, litigation on my behalf and remedies due under any applicable state or federal law, or plan language provision.

I authorize the release of any information pertinent to my case to any insurer, adjuster, government agency or attorney as may be required to enforce my rights and the rights of Provider hereunder. A copy of this Assignment shall be treated as an original. I have read and understand the foregoing, and hereby authorize Provider to provide medical care that is reasonable and at the standard of care as required by state law, and as set forth herein.

Patient Name:	Patient Signature:
Policy Holder Name: (if different from patient)	Parent/Guardian Signature (if applicable):
Insurance Company: Policy Number:	Date: