



**BCN  
Service  
Company**

A nonprofit corporation and independent licensee  
of the Blue Cross and Blue Shield Association

**Exception Payment Request Form  
For Self-Funded ERISA, Self-Funded non-ERISA**

\_\_\_\_\_  
Group Name

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Subscriber's Name

\_\_\_\_\_  
Date of Service

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Type of Service (CPT or HCPC code)

\_\_\_\_\_  
Contract Number

\_\_\_\_\_  
Quantity

\_\_\_\_\_  
Provider: Physician (First and Last Name,  
specialty)/Hospital Name

\_\_\_\_\_  
Member Diagnosis

\_\_\_\_\_  
Provider BCN Service Company NPI (or PIN)

\_\_\_\_\_  
Provider Contracting Status (par or non-par)

\_\_\_\_\_  
Physician/Hospital Charges

\_\_\_\_\_  
Prescription Drug Name

\_\_\_\_\_  
Prescription Drug Strength

\_\_\_\_\_  
Required Payment Amount

\_\_\_\_\_  
Prescription Drug Payment (if applicable)

ERISA Status  ERISA  ERISA Exempt

**The following applies only to self-funded ERISA groups:**

*The new DOL regulations require all plan fiduciaries to verify that all similarly situated participants in a group health plan are treated in the same manner and that all benefits are paid in accordance with the group's plan documents. Therefore, because the above approved benefit is not part of your group's benefit design, you acknowledge that all other similarly situated plan participants will be entitled to the same benefits effective immediately. You agree that you will work with BCN Service Company to implement this change to be a permanent part of the plan design.*

\_\_\_\_\_  
Signature of Authorized Group Representative

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Please ensure that all necessary documentation (i.e. medical bills is attached to this form when being returned to your BCN Service Company representative.

**To be completed by BCN Service Company**

Special Instructions: \_\_\_\_\_

\_\_\_\_\_  
Signature of BCN Service Company Representative

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date