Blue Cross/Blue Shield
EXTRACT FORM

Provider Instructions:

Please provide a brief description of the service you are providing and why the service may reject and not be paid

ALLERGEN EXTRACT - PER BCBSM RULES - PATIENT RESPONSIBILITY IS DETERMINED BY THE PATIENT NOTIFYNG PROVIDER OR BY CANCELLING APPOINTMENTS THAT THEY ARE NOT FOLLOWING THROUGH WITH THE TREATMENT OR TREATMENT IS NEVER STARTED.

Provider Name(s) Allergy Associates of Western Michigan
3185 Macatawa Dr SW Suite B
Grandville, Michigan 49418-1274

Erica Palmisano, MD
1629367081

Thomas P. Miller, MD
18471210895

Member/Patient Information

Provider Instructions: Please fill in the fields below and have the Blue Cross member/patient sign and date the "Member's acknowlegement and agreement to pay for services" section.

Patient Name	Date of Birth

Member Name	ID/Contract #

Group name and number (excludes Medicare primary, Medicare Advantage and MESSA group members)

Date of Service	Procedure code(s)	Total dollar amount of member responsibility
		$

MEMBER'S acknowledgement and agreement to pay for services

My health care provider has notified me that the services listed above may not be payable by Blue Cross Blue Shield of Michigan in the event treatment is not continued or treatement is not started. I understand that payment for these services will be my responsibility. I agree to be responsible for payment.

Member/Patient signature	Date (MM/DD/YYYY)