

Patient Name:

Date:

Insurance:

ID#:

ADVANCED BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If your insurance carrier doesn't pay for services rendered, you may have to pay. Your insurance carrier does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance carrier may not pay for the _____.

WHAT YOU NEED TO DO NOW:

Read this notice so you can make an informed decision about your care.

Ask us any questions that you may have after you finish reading.

Choose an option below about whether to receive the procedure listed above.

_____ Option 1. I want the procedure listed above. You may ask to be paid now but I also want my insurance carrier to be billed for an official decision on payment, which is sent to me on an explanation of benefits. I understand that if my insurance carrier does not pay I am responsible for payment, but I can appeal to my insurance carrier by following the directions on the explanation of benefits. If the insurance company does pay, you will refund any payments I made to you, less co-pays or deductibles.

_____ Option 2. I want the procedure listed above but do not bill my insurance company. You may ask to be paid now as I am responsible for payment. I cannot appeal if insurance company is not billed.

_____ Option 3. I do not want the procedure listed above. I understand with this choice I am not responsible for payment and I cannot appeal to see if my insurance carrier would pay.

Signing below means that you have received and understand this notice. You also receive a copy.

Signature

Date