Date: **Patient Name:** **DOB:**

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving the procedure/injection.

We expect that your insurer will not pay for the procedure/injection that is described below. Your insurer does not pay for all of your health care costs. It only pays for covered items and services when certain rules are met. The fact that your insurer may not pay for a particular item or service does not mean that you should not receive it. There may be good reason your doctor recommended it. Right now, in your case, **your insurer probably will not pay for the procedure/injection indicated below for the following reasons:**

Procedure/Injection	Reason Insurer may not pay for this/these tests as	Estimated Cost:
99205 -new patient 99215 – returning patient (within 3 years) Infertility Appointment	Not medically necessary	$375 - $475

The purpose of this form is to help you make an informed choice about whether or not you want to receive this procedure/injection knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain if you do not understand why your insurer probably will not pay.
- Ask us how much the procedure/injection will cost you (Estimated cost is $1,600) in case you have to pay for them yourself or through other insurance.

OPTIONS: Please choose an option. Check only ONE box. SIGN AND DATE your choice.

❑ OPTION 1. YES. I want to receive the service/procedure/injection.

I understand that my insurer will not decide whether to pay unless I receive the service/procedure/injection. Please submit my claim to my insurer. I understand that you may bill me for the procedure/injection and that I may have to pay the bill while my insurer is making its decision. If my insurer does pay, you will refund to me any payments I made to you that are due to me. If my insurer denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have.

❑ OPTION 2. NO. I have decided not to receive the injection/procedure.

I will not receive the procedure/injection. I understand that you will not be able to submit a claim to my insurer and that I will not be able to appeal your opinion that it will not pay. I will notify my doctor who ordered the procedure/injection that I did not receive it.

Signature:	Date:

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurer, your health information on this form may be shared with your insurer.