Patient's Name: Insurance # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.
We expect that your insurance will not pay for the item(s) or service(s) that are described below. Your insurance does not pay for all of your health care costs. Insurance only pays for covered items and services when rules are met. The fact that insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare, Medicaid, Blue Cross and other insurances, probably will not pay for -

☐ **Medicare** ☐ **Medicaid** ☐ **BCBS** ☐ **Other Insurance** _____

Procedure	**CPT**	**Dx**	**Fee**
Preventative Office Visit			
Annual Pap			
Injections			
Office Procedure			
Hospital Surgery			
Laboratory Sample			
Other _____			

Not Covered Because:

☐ Deductible _____ %
☐ Inactive Coverage
☐ Lifetime Benefit Maximum Reached
☐ Not Covered Service
☐ Pre-existing Condition
☐ Not Eligible Dependent
☐ Not Medically Necessary
☐ Precertification / Preauthorization Needed
☐ Other _____

NOTE:** ***ANY pap that the contracted Pathologist sees suspect may be sent to a Specialty Lab; which will be out of network. This applies to all insurances. Patient will be billed for this service.

_____
Signature of Patient or person acting on patient's behalf

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, 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 don't understand why your insurance probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $** _____), in case you have to pay yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

☐ **OPTION 1. YES. I want to receive these items or services.**
I understand that my insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If insurance does pay, you will refund to me any payments I made to you that are due to me. If insurance denies payment, I agree to be personally responsible for payment. That is, I will pay personally, either out of my pocket or through any other insurance that I have. I understand I can appeal my insurance's decision.

☐ **OPTION 2. NO. I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance won't pay.

_____ _____
Date **Signature of patient or person acting on patient's behalf.**

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