Allergy & Dermatology specialists

PHOENIX GLENDALE SUN CITY SUN CITY WEST

Advance Beneficiary Notice (ABN)
Non-Medicare

Patient Name: _____ Insurance ID# _____

Note: You need to make a choice about receiving these health care items or services.

We expect that your insurance company will not pay for the item(s) or service(s) that are described below. Your Insurance Company does not pay for all of your health cares costs. Your Insurance Company only pays for covered items and services when your insurance company's rules are met. The fact that your insurance company 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, your Insurance Company probably will not pay for**:

Item or Service: **Because**:

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 do not understand why your Insurance Company probably will not pay.
- Ask us how much these items or services will cost you *(Estimated Cost:* $_____)

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

☐ **Option 1: Yes, I want to receive these items or services.**
I understand that my Insurance Company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my Insurance Company is making its decision. If my insurance company does pay, you will refund me any payments I made to you that are due to me. If my Insurance Company 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. I understand I can appeal my Insurance Company'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 company and that I will not be able to appeal your opinion that my insurance company will not pay.

_____ _____

SIGNATURE of patient or person acting on patient's behalf **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 insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.