EF 9.4

ADVANCE BENEFICIARY NOTICE
Insurance

Patient Name | Date

NOTE: Your insurance 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 may not pay for the **Test(s) / Procedure(s)** below. If your insurance doesn't pay for **Test(s) / Procedure(s)** below, **you may have to pay.**

Test(s) / Procedure(s):	Reason Your Insurance May Not Pay:	Estimated Cost:
_____	☐ Service is not covered for your condition.	_____
_____	☐ Service is only allowed once per week / month / 6 months / year.	_____
_____	☐ Service is considered experimental or research use by Your Insurance.	_____

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 **Test(s) / Procedure(s)** listed above.

NOTE: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **Test(s) / Procedure(s)** listed above. You may ask to be paid now, but I also want insurance billed for an official decision on payment, which is sent to me on an insurance Summary Notice (MSN). I understand that if insurance doesn't pay, I am responsible for payment, but **I can appeal to insurance** by following the directions on the MSN. If insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **Test(s) / Procedure(s)** listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed.**

☐ **OPTION 3.** I don't want the **Test(s) / Procedure(s)** listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if insurance would pay.**

Additional Information:

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or insurance billing, call your insurance company. Signing below means that you have received and understand this notice. You also receive a copy.

For Office Use: ☐ Beneficiary refused to choose an option.

Patient or person acting on patient's behalf _____ **Date** _____