Sigma Eyehealth Centers

Patient's Name: _____ Date:_____

ADVANCE BENEFICIARY NOTICE (ABN)

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

We expect that your insurance may not pay for the item(s) or service(s) that are described below. Insurance does not pay for all of your health care costs; insurance only pays for covered items and services when insurance 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 you doctor recommended it.

In your case, insurance may not pay for:

Items or Services: Including but not limited to Examination, Refraction, Visual Field Testing, Photographs, Medications, Dressings, Special Testing, and Eyewear such as Frames, Lenses, and Coating.
Because: These items or services are non-covered items or do not meet the rules set by the insurance company's guidelines.

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 insurance probably won't pay.
- ❖ Ask us how much these items or services will cost you in case you have to pay for them yourself or through other insurance. (Estimated Cost: $_____)

PLEASE CHOOSE ONE OPTION, CHECK ONE BOX, SIGN AND DATE YOUR CHOICE.

☐ ***Option 1.*** **YES, I want to receive these items or services.** I understand that insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to insurance. I understand that you may bill me for items or services and that I may have to pay the bill while insurance is making its decision. If insurance 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 the 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 insurance and that I will not be able to appeal the denial by insurance.

_____ _____

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 offices. If a claim is submitted to insurance, your health information on this form may be shared with the insurance company.