Patient's Name: _____ Account # _____

Date of Birth: _____ Blue Cross/Other Insurance #: _____

## ADVANCED BENEFICIARY NOTICE (ABN)

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

We expect that Blue Cross/Other Insurance will not pay for the item(s) or service(s) that are decribed below. Blue Cross/Other Insurance does not pay for all of your health care costs. Blue Cross/Other only pays for covered items and services when Blue Cross/Other rules are met. The fact that Blue Cross/Other may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason for your doctor to recommend it. Right now, in your case, Blue Cross/Other probably will not pay for:

| Item(s) or Service(s) |
|---|
| 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 may 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 Blue Cross/Other Insurance probably will not pay. Ask us how much these items or services will cost you (Estimated cost $_____), in case you have to pay for them yourself or through other insurance.

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

☐ Option 1. YES, I want to receive these items or services

I understand that Blue Cross/Other Insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to Blue Cross/Other Insurance. I understand that you might bill me for items or services, and that I may have to pay the bill while Blue Cross/Other Insurance is making the decision. If Blue Cross/Other Insurance does pay, you will refund to me any payments I made to you that are due to me. If Blue Cross/Other 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 other insurance that I have. I understand Blue Cross/Other Insurance's decisions.

☐ 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 bale to submit a claim to Blue Cross/Other Insurance, and that I will not be able to appeal your opinion that Blue Cross/Other Insurance will not pay.

_____/_____/_____ _____

Date Signature or 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 Blue Cross/Other Insurance, your health information on this form may be shared with Blue Crosss/Other Insurance. Your health information which Blue Cross/Other Insurance sees will be kept confidential by Blue Cross/Other Insurance.