Washington Center for Pain Management

Patient's Name: _____

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. Your insurance only pays for covered items and services when your insurance rules are met. The fact that you 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, **your insurance probably will not pay for-**

Items or Services:
Telehealth Followup Visit
Because:
This service may not be covered for your condition or it may be deemed as medically unnecessary or investigational

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: $ 55), in case you have to pay for them yourself.

****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. 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 and fully responsible for payment. I understand I can appeal my insurances 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 insurance won't pay.

_____ _____

Date Signature of patient or person acting on patient's behalf

Revised 8/13/2013