Advance Beneficiary Notice

Practice Name:

Address: Phone: XXX-XXX-XXXX

Your child is due for the following tests/procedures (see below). Your insurance may or not pay for these services. Insurance plans do not pay for everything, even some services that you or your health care provider have good reason to believe you need.

|  |  |  |
| --- | --- | --- |
| Test / Procedure | Insurance | Estimated Cost |
| Instrument Based Photoscreening | This test may not be a covered under your plan | $XX.XX |

What you need to do:

* Read this notice so you are able to a decision about your child’s care
* Ask us any questions that you may have after reading
* Select an option below to choose whether to receive the service listed above

|  |
| --- |
| Options: Check only one box. We cannot choose a box for you. |
| * OPTION 1 – I want the service listed above. You may ask for payment now, and agree to bill my insurance. I understand that if my insurance doesn’t pay, I am responsible for payment. If my insurance does pay, you will refund any payments I made to you, less applicable co-pays or deductibles.
* OPTION 2 – I want the services listed above. You may ask for payment now, and agree not to bill my insurance as I will take responsibility for payment.
* OPTION 3 – I DO NOT want the services listed above.
 |

Signing below means that you have received and understand this notice. You may also receive a copy.

|  |  |
| --- | --- |
| Signature: | Date: |