

Patient's Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If your insurance doesn't pay for the procedures/services below, you will be responsible for payment.

Insurance does not pay for everything, even some care that you or your health care provider believe you may need. We expect insurance may not pay for the procedures/services below.

Procedures and Services	Reason Insurance May Not Pay	Estimated Cost
<small>(check all that apply)</small> _____ Computer-assisted navigational procedure	considered "experimental"	\$400.00
_____ Assistant surgeon	considered assistant surgeons "not medically necessary" for _____ procedure, or provider considered "non-participating"	\$300.00
_____ Other	_____	\$ _____.

**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 procedure/services listed above.

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

**OPTION 1.** I want the procedures/services listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance by following the directions on the EOB.

**OPTION 2.** I don't want the procedures/services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

**Additional Information:** If both "computer-assisted navigational procedure" and "assistant surgeon" are checked above, the estimated cost is \$700.00 for both of these procedures/services. Your insurance plan may consider an assistant surgeon "not medically necessary" for some or all parts of your surgery, even if your physician feels an assistant is necessary.

**This notice gives our opinion, not an official decision by your insurance.** If you have other questions about your insurance coverage, please contact your insurance carrier directly. Signing below means that you have received and understand this notice.

Signature: _____	Date: _____
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