

A. Notifier: Triangle Visions Optometry

B. Patients Name: _____

C. Identification Number: _____

Advance Beneficiary Notice of Noncoverage (ABN)

Note: If your insurance does not pay for D. services below, you may have to pay. Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need.

We expect your insurance may not pay for the D. services below.

D. Services	E. Reason Your Insurance May not Pay:	F. ESTIMATED COST
<input type="checkbox"/> Refraction \$60 <input type="checkbox"/> Optos Photos \$39 <input type="checkbox"/> Retinal Photos \$95 <input type="checkbox"/> Visual Field \$120 <input type="checkbox"/> OCT \$120 <input type="checkbox"/> Ortho K \$575-\$4,400 <input type="checkbox"/> Contact Fitting \$80-\$225 <input type="checkbox"/> Routine Exam \$140-\$160	<input checked="" type="checkbox"/> Your insurance usually does not pay for these services, even though it may agree with the validity of the procedure. <input checked="" type="checkbox"/> Your insurance may not pay for these services if they are not deemed medically necessary by your insurance company. <input checked="" type="checkbox"/> If no medical findings are discovered during this visit, your medical insurance may deny coverage.	See Section D.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading,
- Choose an option below about whether to receive the D. services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but insurance cannot require us to do this.

<p>G. OPTIONS: INITIAL ONLY ONE. We cannot choose for you.</p> <p><input type="checkbox"/> OPTION 1: I want the <u>D. services</u> listed above. You may be asked to pay now, but I also want my insurance billed for an official decision on payment. I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance by contacting them. If my Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.</p> <p><input type="checkbox"/> OPTION 2: I want the <u>D. services</u> listed above at the rate indicated, but do not bill my insurance. You may be asked to pay now as you are responsible for payment. I cannot appeal if my insurance is not billed.</p> <p><input type="checkbox"/> OPTION 3: I do not want the <u>D. services</u> listed above. I understand with this choice I am responsible for payment, and I cannot appeal to see if my insurance would pay.</p>
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H. Additional Information

This notice gives our opinion, but is not an official decision by your insurance company. If you have other questions on this notice, your insurance, or Medicare billing, contact your insurance company or call **1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).**

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

I. Signature :	J. Date:
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