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
___Refraction $60 ___Optos Photos $39 ___Retinal Photos $95 ___Visual Field $120 ___OCT $120 ___Ortho K $575-$4,400 ___Contact Fitting $80-$225 ___Routine Exam $140-$160	_X__ Your insurance usually does not pay for these services, even though it may agree with the validity of the procedure. _X__ Your insurance may not pay for these services if they are not deemed medically necessary by your insurance company. _X__ 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.

G. OPTIONS: INITIAL ONLY ONE. We cannot choose for you.
____**OPTION 1:** I want the **D.** services listed above. You may be asked to pay now, but I also want my insurance billed for an offical 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. ____**OPTION 2:** I want the **D.** services 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.** ____**OPTION 3:** I do not want the **D.** services listed above. I understand with this choice I am responsible for payment, and **I cannot appeal to see if my insurance would pay.**

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:

CMD does not discriminate in its programs and activites. To request this publication in an alternative format, please call 1-800-MEDICARE or email: AltFormatRequest@cmd.hhs.gov