A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If your insurance doesn't pay for **D.** SARS-CoV-2 below, you may have to pay the full price charged. Your insurance ___________________________ may not offer coverage for the following services.

D.	E. Reason Insurnace May Not Pay:	F. Estimated Cost
Covid-19 screening test	Routine testing due to exposure or for administrative purposes is often not a covered benefit.	$95.00

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 **D.** _____________ as above.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want the **D.** _____________ listed above. I know I am expected to pay now, but I also want my insurance billed for an official decision on payment, which is sent to me as an Explanation of Benefits. I understand that if my insurance doesn't pay, I am responsible for the full billed amountnt, but **I can appeal this decision with my insurance company.** If does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.** _____________listed above, but do not bill my insurance. I will be asked to pay now as I am responsible for payment
☐ **OPTION 3.** I don't want the **D.** _____________ listed above. I understand with this choice I am **not** responsible for payment**.**

H. Additional Information:

This notice gives our opinion, not a denial from your insurance company. If you have other questions on this notice please ask the front desk person, the billing person, or the physician before you sign below. Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: