**ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)**

***NOTE:*** You need to make a choice about receiving these health care items or services.

We expect that your insurance company may not pay for the item(s) or service(s) that are described below. Insurance companies do not pay for all your health care costs. Most insurance companies only pay for covered items and services when certain rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. Insurance companies do not pay for everything, even though your doctor may have a good reason to recommend it. We expect your insurance company may not pay for the item(s) or service(s) listedbelow. Please note that this list may not include all items or services your doctor may recommend that your insurance company may not cover.

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| **Injections: platelet-rich plasma (PRP), prolotherapy, joint, ligament/tendon/muscle, trigger point****Treatments: acupuncture, cupping, mesotherapy, osteopathic manipulation (OMT), physical therapy****Vaccines:yellow fever, HPV, typhoid fever, meningitis, rabies, MMR, Hepatitis A/B, tetanus, polio****Services: deductibles, coinsurances, co-pays for preventive and/or sick visits, travel consultations** |

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

**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.
* Ask us to explain, if you don’t understand, why your insurance company won’t pay.
* Ask us how much these items or services will cost you in case you have to pay for them yourself or through other insurance.



**Integrative Family Medicine**

**Sports Medicine at Chelsea**

**Please initial only one box. We cannot choose a box for you.**

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| **\_\_\_\_\_Option 1. IF my provider recommends the services described above, AND I agree to receive the services - Yes; I want to receive these items or services described above.** I understand that my insurance company will not decide to pay unless I receive these items or services. Please submit my claim. I understand that you may bill me for the items or services and that I may have to pay the bill while my insurance company is making a decision. If my insurance company should pay, you will refund me any monies I have paid. If payment is denied I will pay personally. I understand that I can appeal the insurance company’s decision not to pay. |
| **\_\_\_\_\_Option 2. No. I have decided not to receive these items or services**I choose not receive the items or services described above. I understand that you will not submit a claim for these services and that I will not be able to appeal your opinion that my insurance will not pay.  |

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

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**www.sportsmedchelsea.com www.integrativefamilymed.com**