A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance carrier doesn't pay for **D. lab tests** 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 carrier may not pay for the **D. lab tests** listed below.

D. Checked Lab Tests Only:	□ MMP-9, 83516 Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semi-quantitative, multiple step method.		
E. Reason Your Insurance May Not Pay:	They do not pay for these tests for your condition.	They do not pay for these tests as often as ordered for you.	They do not pay for experimental or research use tests.
F. Estimated Cost:			

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. lab tests** listed above.

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

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

☐ **OPTION 1.** I want the **D. lab tests** listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment. I understand that if my insurance carrier doesn't pay, I am responsible for payment, but **I can appeal to my insurance carrier** by following their policies for appeal. 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. lab tests** listed above, but do not bill my insurance carrier. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance carrier is not billed**.

☐ **OPTION 3.** I don't want the **D. lab tests** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance carrier would pay.**

H. Additional Information:

This notice gives our opinion, not an official insurance carrier decision. If you have other questions on this notice or insurance billing, please call your insurance carrier.

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

I. Signature:	**J. Date:**