Pulmonary and Sleep Medicine Center of Winder

20 Satellite Dr. Ste 200, Winder, GA 30680
Phone (770) 586-0300, Fax (770) 586-0311

Patient Name: ________________________ Ins. Plan Name:______________________________

Advance Beneficiary Notice of Non-coverage (ABN)

Note: If a referral or authorization for services is required by your insurance plan from your Primary Care Physician and not obtained you may be responsible for full payment of these services.

Your insurance company does not pay for all services, even some care that you or I have good reason to think you need. We expect that the services listed below may not be covered by your insurance plan:

CPT Code	Description	Estimated Cost
1.		
2.		
3.		
4.		
5.		

Office Use Only: **PR19**-Workman Comp Claim **PR20**-Third Party Liability **PR21**- MVA covered under PIP Insurance **PR96**- Non Covered Services **PR119**- Maximum benefits have been reached **PR15**- Referral/Authorization Missing

What You Need To Do Now:

- Read this notice so that 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 to receive the services listed above.
  (If you choose option 1 or 2, we may help you to use another insurance that you might have, but your insurance company cannot require us to do this).

Options	Check only one box. We cannot choose the box for you
[ ] Option 1	I want the services listed above [list line number/s] Number:___________________ I may be asked to pay now but your plan will also be billed for an official decision on payment. I understand that my plan doesn't pay; I am responsible for full payment. ***I can appeal to my insurance plan*** by following the directions specified in my benefits handbook. If your plan does pay, I will refund you any payments which you made, less co-pays or deductibles.
[ ] Option 2	I want the services listed above [list the number/s] Number:___________________ Do not bill my insurance plan, I am aware that I am responsible for the bill; ***I cannot appeal to my insurance plan*** if this claim is not submitted to my insurance plan.
[ ] Option 3	I don't want the services listed above [list the number/s] Number:________________ I understand with this choice I am not responsible for the payment and ***I cannot appeal to see if my insurance plan would pay***.

This notice gives our opinion, not an official decision by your insurance plan. If you have other questions about the notice or policies of your insurance plan, please contact customer service department of your plan at the number located on your insurance card.

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

Signature:	Date: