

(A) Notifier: Animas Anesthesia Associates, LLC

(B) Patient Name: _____ (C) Identification Number: _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If your insurance company doesn't pay for **(D)Anesthesia** below, you may have to pay.

Your insurance company may 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 company may not pay for the **(D)Anesthesia** below.

(D) Anesthesia	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
Anesthesia for endoscopic procedure	Your insurance company may not consider this service to be medically necessary	\$150 (if claim denied)*

**The estimated personal liability of \$150 will be assessed if your insurance company denies payment on your claim for anesthesia services. If your insurance company processes your claim as a benefit your personal liability will be determined in accordance with your plan benefits*

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)Anesthesia** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have.

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

OPTION 1. I want the **(D) Anesthesia** listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on an Explanation of benefits (EOB). I understand that if my insurance company doesn't pay, I am responsible for payment, but **I can appeal to my insurance company** by following the directions on the EOB. If my insurance company does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the **(D) Anesthesia** listed above, but do not bill my insurance company. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance company is not billed.**

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

(H) Additional Information:

This notice gives our opinion, not an official insurance company decision. If you have other questions about this notice please contact your insurance company at the number listed on your insurance card. Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature: _____

(J) Date: _____