Patient's Name: _____
Medicare or Private Insurance # (HICN): _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. If Medicare or your Private Insurance does not pay for item(s) or service(s) that are described below:

Custom Oral Appliance

Medicare or your Private Insurance may not pay for all or some of your health care costs. Your insurance only pays for covered items and services when their rules are met. The fact that they may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, your insurance may not pay for Items or Services listed below:

Custom Oral Appliance

Because:

- Secondary Deductible may have not been met
- AHI too Low
- Need to try CPAP first
- Open Workman's Comp case or No-Fault case
- Do not have benefits for this procedure

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.

- Ask us to explain, if you don't understand why your insurance company probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: $_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX WITH YOUR INITIALS. SIGN & DATE YOUR CHOICE.

Option 1

_____YES: I want to receive these items or services.
I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance company is making its decision. If my insurance company does pay, you will refund to me any payments I made to you that are due to me. If my insurance company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance company's decision.

Option 2

_____NO: I have decided not to receive these items or services. I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company won't pay.

_____
Date

_____
Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare or your Private Insurance, your health information on this form may be shared with Medicare or your private insurance, your health information which Medicare sees will be kept confidential by Medicare or your Private Insurance.