A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare or your commercial insurance payer doesn't pay for items listed in table **D.** below, you may have to pay.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
Telehealth Visit	Not a covered benefit	$100

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. telehealth service** listed above.

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

☐ **OPTION 1.** I want the **D. telehealth service** listed above. I understand that if Medicare or my commercial insurance doesn't pay, I am responsible for payment, but **I can appeal to Medicare or my commercial insurance.** If Medicare or the commercial insurance plan does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. telehealth service** listed above, but do not bill Medicare or my commercial insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare or my commercial insurance is not billed**.

☐ **OPTION 3.** I don't want the **D. telehealth service** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare or commercial insurance would pay.**

H. Additional Information:

Signing below means that you have received and understand this notice.

I. Signature:	J. Date:

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