Acknowledgment of Financial Responsibility

Advance Beneficiary Notice of Non-coverage for DME & Medical Supplies

Notifier: **Some Other Company, Inc DBA Pretty in Pink Boutique** Date of Service: _____

Patient Name: _____ Date of Birth (MM/DD/YYYY): _____

Primary Insurance: _____Policy Number: _____

Secondary Insurance: _____Policy Number: _____

When an item or service isn't reasonable and necessary or more than the number of services allowed in a specific period for that diagnosis, we expect that your health care benefits insurer or administrator may not pay the full retail price for the items that are listed below.

Note: You need to make a choice about receiving these health care items. Please read this entire notice carefully.

If your health care insurer/administrator doesn't pay for the items listed below you may have to pay.

D: (List Procedure Code/ Item Description)	Reason Insurance May Not Pay	Estimated Cost
	Non-Covered Services/Supplies	
	Non-Covered Services/Supplies	
	Non-Covered Services/Supplies	
	Non-Covered Services/Supplies	
	Non-Covered Services/Supplies	

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**_____ listed above.

OPTIONS: *Check only one box. We cannot choose a box foryou.*

☐ **OPTION 1.** I want the items 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 insurance doesn't pay, I am responsible for payment. If your insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

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

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

C O N S E N T F O R P A Y M E N T

Authorization to Assign Benefits to Provider (Consent for Payment): I assign the right and responsibility to Some Other Company, Inc DBA Pretty in Pink Boutique to bill on my behalf and accept payment for DMEPOS products and services provided to me, the Beneficiary. I understand that I am responsible to pay any deductible amount applied to the claims and the coinsurance, which is _____ **%** of the allowable or approved charge for a product or service. I permit Some Other Company, Inc DBA Pretty in Pink Boutique to release and collect my health information, and other information, as required (and as permitted by the HIPAA Regulations) from my health care providers to receive payment by my insurance. I understand that this form will be maintained and made available to my insurance or its representatives.

I have been informed that my insurer or administrator may not cover the items listed above in full. Pretty In Pink Boutique has also informed me about alternative items, if any, that may be covered by my insurer. If insurance does pay, Pretty in Pink Boutique will refund to me any payments I made to them that are due to me. If my insurer denies payment, I agree to be personally and fully responsible for the payment.

I understand that this cost difference may not appear as *patient responsibility* or listed on my insurer's Explanation of Benefits.

By signing this form, I certify that I elect to receive these items and pay the amounts disclosed to me by Some Other Company, Inc DBA Pretty in Pink Boutique.

Patient Signature: _____ Date: _____

If the beneficiary or their representative refuses to choose an option or sign the ABN, you should note that on the ABN. You may list refusal witnesses, but it's not required. If a beneficiary refuses to sign a correctly issued ABN, the provider may consider not providing the DME supplies.