A. Notifier: Allergy & Immunology Medical Center

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

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If your insurance doesn't pay for **D. New Patient Evaluation** below, you may have to pay. Your insurance does 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 may not pay for the **D. New Patient Evaluation** below.

D. New Patient Evaluation	E. Reason Your Insurance May Not Pay:	F. Estimated Cost
CPT Code 99205 New Patient Evaluation (Level 5)	"Exceeds Unit Restrictions" or not considered "Medically Necessary" or "Bundled" with other provided services.	$250
CPT Code 99354 1 hour beyond regular service (billed at >90 min)		$145
CPT Code 99355 Additional 30 min beyond extra 1 hour above service (billed at >135 min)		$110
CPT Code 94060 Pre/Post Bronchodilator Lung Function Test		$55
CPT Code 94760 Non-invasive Pulse Oximetry		$3
CPT Code J7620 Albuterol Ingestion Solution		$5
CPT Code A7003 Respiratory Supplies		$2
CPT Code A4617 Spirometry Mouthpiece		$3

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. New Patient Evaluation** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance cannot require us to do this.

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

☐ **OPTION 1.** I want the **D. New Patient Evaluation** 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). If my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance.

☐ **OPTION 2.** I want the **D. New Patient Evaluation** 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 **D. New Patient Evaluation** listed above. I understand with this choice I am **not** responsible for payments, and I cannot appeal to see if my insurance would pay.

H. Additional Information:

This notice gives our opinion, not an official insurance decision.

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

I. Signature:	**J. Date:**