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. Rush Immunotherapy** 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. Rush Immunotherapy** below.

D. Skin Testing	E. Estimated Cost	F. Reason Your Insurance May Not Pay:
CPT Code 95165 Extract Preparation	$4,000 to $10,000	Ask if any of the below reasons or ANY OTHER REASONS may cause your insurance to not pay: • "Exceeds Unit Restrictions" • Not considered "Medically Necessary" • "Bundled" with other provided services • "Prior Authorization" required
CPT Code 95180 Rapid Desensitization	$4,000 to $5,000	
CPT Code 99215 Office Visit	$205.00 per visit	
CPT Code 94010 Lung Function Breathing Test	$35.00 per visit	
CPT Code 95117 Allergy Injections	$15.00 per visit	

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. Rush Immunotherapy** 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. Rush Immunotherapy** 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. Rush Immunotherapy** 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. Rush Immunotherapy** 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: