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. Skin Testing** 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. Skin Testing** below.

D. Skin Testing	**E. Estimated Cost**	**F. Reason Your Insurance May Not Pay:**
CPT Code 95004 Percutaneous Skin Testing	$650	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 95024 Intradermal Skin Testing	$800	
CPT Code 95017 Venom Skin Testing	$220	
CPT Code 95018 Drug Skin Testing	$550	
CPT Code 95076/95079 Ingestion Challenge	$540	
CPT Code 94010 Lung Function Breathing Test	$35	

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. Skin Testing** 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. Skin Testing** 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. Skin Testing** 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. Skin Testing** 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:**