Ravi Kant, MD, P.C.
300 Old Pond Rd. Ste. 201 Bridgeville, Pa. 15017

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Patient's Name _____Date of Birth_____

Insurance Plan_____ ID#_____

If the insurance plan does not pay for the medical services listed below, or we do not participate in your insurance plan, you will be required to pay out of pocket. The insurance plans do not pay for everything, even some care that you or your health care provider have good reason to think you need.

Service(s)/Reason(s): (Check one) □ Tele-Psychiatry □ Non Par w/ Insurance or □ Other: _____

Reason the Insurance Plan May Not Pay: Non-covered service or Not in network provider

Estimated cost: _$85-$250 depending on treatment. Cost may vary depending on the service/s

WHAT YOU NEED TO DO NOW:
Read this notice, so you can make an informed decision about your care. Please feel free to ask any questions that you may have after you finish reading this form. Choose the preferred option below.

Check only one box. We cannot choose a box for you.

□ **Option. 1.** I want the medical service/s listed above. I will be asked to pay now, and I also want the insurance company billed for an official decision on payment. This is sent to me on an Explanation of Benefits (EOB) from the insurance company. I understand that if the insurance plan does **not** pay, I am responsible for payment, but I can appeal to the insurance plan by following the directions on the EOB. If the insurance plan does pay, NeuroPsychiatry Center will refund any payments I made to you, less co-pays or deductibles.

□ **Option 2.** I want the service/s listed above, but do not bill the insurance plan. I will be asked to pay now as I am responsible for payment**. I cannot appeal if the insurance plan is not billed.**

□ **Option 3.** I do not want the service/s listed above. I understand with this choice, I will not receive the services listed above and I am not responsible for payment, **I cannot appeal to see if the insurance would pay.**

This notice is not an official insurance plan decision. If you have other questions on this notice regarding insurance billing, please call your insurance company. Signing below means that you have received and understand this notice. You may also receive a copy.

Signature:_____ Name:_____Date:_____

Office Use Only

Witness: _____ Name: _____Date:_____