Patient Name:______________________________ **DOB**:__________________________________

Insurance Provider:__________________________ **Identification Number**:___________________

Advance Patient Notice of Noncoverage

NOTE: If your insurance doesn't pay for the items listed in (A) below, you may have to pay. 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 that your insurance provider may not pay for the following:

A. Services	B. Reason Your Insurance Provider May Not Pay:	C. Estimated Cost
i. UTMC facility charge.	i. UTMC is not a participating facility with your insurance provider.	i. $245.00
ii. Physician charges.	ii. Dr. Grubb is not a participating provider with your insurance provider.	ii. $907.00

There may be additional services and/or charges that are not covered by your insurance. This is only an estimate.

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 services listed in (A) 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.

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

☐ **OPTION 1.** I want the **services listed in (A)** above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment. I understand that if my insurance provider doesn't pay, I am responsible for payment, but **I can appeal to my insurance provider** by following the directions on the denial. If my insurance provider does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **services listed in (A)** 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 provider is not billed**.

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

Additional Information:

This notice gives our opinion, not an official insurance provider decision. If you have other questions on this notice or your insurance provider billing, please contact your insurance provider directly.

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

Signature:	Date: