# *Richmond Allergy and Asthma Specialists, P.C.*

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## ADVANCE NOTICE OF NON-COVERAGE – NON-MEDICARE (Serum)

Patient Name:_____ MR #:_____

We expect that your insurance company will not pay for the items or services that are described below. Your insurance company only pays for covered items and services when its rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. There may be good reasons your doctor recommended it.
Right now, in your case, your insurance company probably will not pay for:

| Item or Service (including CPT code) | Reasons Your Insurance May Not Allow |
|---|---|
| Serum preparation (95165) | May exceed insurance frequency limitation |

**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 and/or items listed above.

The estimated costs for these items or services is: $_____.
**Your charges may or may not exceed this number as it is only an estimate.**

Please review the options below and check only one box. We cannot choose a box for you.

___ OPTION ONE
I want the items and services listed above. I may be asked to pay now, but I also want my insurance to be billed in the event that the services are a covered benefit. I understand that if my insurance does not provide coverage, I am responsible for payment. If my insurance does allow coverage, you will refund any payments I made to you, less co-pays or deductibles.

___ OPTION TWO
I want the items and services listed above, but do not bill my insurance. I may be asked to pay now as I am responsible for payment. **I cannot appeal if my insurance is not billed**.

___ OPTION THREE
I don't want the items and services listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if my insurance would allow.**

This waiver will remain in effect for your entire plan year. You may revoke this waiver at any time by providing written notice of your revocation to the practice.

This notice gives our opinion; it is not a denial from your insurance company. If you have questions about this notice please ask us before you sign below. Signing below means that you have received and understand this notice. You also will receive a copy.

| **Signature:** | **Date:** |
|---|---|
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