THE University of Vermont HEALTH NETWORK

Porter Medical Center

UVMHN: Porter Medical Center
Town, VT zip code
Inquires: 802-388-8808
Option 5 – Financial Advocate

Name: _____

DOB: _____

Acct#: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance Company doesn't pay for the Test or Procedure listed below, you may have to pay out of pocket. *We expect that they may not pay for the Test/Procedure below.*

Test or Procedure	Reason They May Not Pay:	Estimated Cost
	☐ Your insurance does not cover this item or service for your condition. ☐ Your insurance does not cover this item or service more often than_____. ☐ Other: _____ _____.	

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 Test or Procedure listed above.

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

☐ **OPTION 1.** I want the tests or procedures listed above. You may ask me to pay now, but I also want my insurance billed for an official decision on payment. I understand that if they do not pay, I am responsible for payment, but **I can appeal to My Insurance.** If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the tests or procedures listed above but do not want you to bill my insurance. You may ask me to pay now as I am responsible for payment. **I cannot appeal if my insurance is not billed**.

☐ **OPTION 3.** I don't want the tests or procedures listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance would pay.**

Additional Information:

This notice gives our opinion, not an official Insurance decision. If you have other questions on this notice or Insurance billing, please call your Insurance company directly.
Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**