

**Advance Beneficiary Notice**

**Non-Medicare**

Clinic Name

Clinic Site

1 Main Street, Suite 2

City, State ZIP

Telephone: XXX-XXX-XXXX

Fax: XXX-XXX-XXXX

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note: You need to make a choice about receiving these health care items or services.**

We expect that your insurance company will not pay for the item(s) or service(s) that are described below. Your Insurance company only pays for covered items and services when your insurance company’s 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 a good reason your doctor recommended it. Right now, in your case, your Insurance Company may deny the following service**:

**Item or Service:** Whole Body Photography (96904)

**Reason:** Dysplastic Nevus Syndrome, History of Dysplastic Nevus, Family or Personal History of Melanoma

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing you may have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

* Ask us to explain, if you do not understand why your Insurance Company may not pay.
* Know that the cost of the service if denied, your cost will be $\_\_\_\_\_\_\_

I understand that my Insurance Company will not decide whether to pay until after I have received these services. Please submit my claim to my Insurance Company. If my Insurance Company denies payment, I agree to be personally responsible for payment. I also understand I can appeal my Insurance Company’s decision.

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Patient/Guardian Signature: Relationship Date