

A. Notifier: BalanceMD

Insurance Company: _____

B. Patient Name: _____

C. Identification Number: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: IF your insurance company doesn't pay for D. ***Virtual Visit*** below, you may have to pay. Although there is a state law in Indiana requiring health insurance companies to cover Telemedicine (virtual visits), not all are complying with this law. Your insurance company may not pay for the D. ***Virtual Visit*** below.

D. Service	E. Reason:	F. Estimated Cost
Telemedicine, aka Virtual Visit	Your insurance company may not cover this testing	\$75.00

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 D. ***Virtual Visit*** listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but we are not required to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
<input type="checkbox"/> OPTION 1. I want the (D.) <i>Virtual Visit</i> listed above. You may ask to be paid now, but I also want my insurance company billed for an official decision on payment, which is sent to me on an explanation of benefits (EOB). I understand that if my insurance company doesn't pay, I am responsible for payment, but I can appeal to my insurance company by following the directions on the EOB. If my insurance company does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/> OPTION 2. I want the (D.) <i>Virtual Visit</i> listed above, but do not bill my insurance company. You may ask to be paid now as I am responsible for payment. I cannot appeal if my insurance company is not billed.
<input type="checkbox"/> OPTION 3. I don't want the (D.) <i>Virtual Visit</i> listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if my insurance company would pay.

H. Additional Information:

This is not an official insurance company decision. If you have other questions on this notice or billing, call the customer service number on the back of your insurance card. Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date Signed:
	K. Date of Service:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.