A. Notifier: BalanceMD **Insurance Carrier:**
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If insurance doesn't pay for D. cVEMP below, you may have to pay.

Some 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 your insurance may not pay for the **D. cVEMP** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
VEMP testing	Some insurances may not cover this testing	$110.00

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. cVEMP** listed 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.

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

□ **OPTION 1.** I want the **D. cVEMP** listed above. You may ask to be paid now, but I also want insurance billed for an official decision on payment. I understand that if insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance individually if desired**.**

□ **OPTION 2.** I want the **D. cVEMP** listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if insurance is not billed.

□ **OPTION 3.** I don't want the **D. cVEMP** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if insurance would pay.

H. Additional Information:

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

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

I. Signature:	J. Date: