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), some plans are excluded and may not pay for the **D. Virtual Visit** below.

D.	E. Reason Insurance May Not Pay:	F. Cost
Telemedicine, aka Virtual Visit, for Follow-up	Your insurance company may not cover this visit type	$128.00

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.

☐ **OPTION 1.** I want the **D. Virtual Visit** 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 a 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.

☐ **OPTION 2.** I want the **D. Virtual Visit** 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**.

☐ **OPTION 3.** I don't want the **D. Virtual Visit** 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 notice gives our opinion, not an official insurance company decision. If you have other questions on this notice or billing, call the customer service number on your insurance card. Signing below means that you have received and understand this notice. You may ask to receive a copy.

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

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.