MANAGED CARE WAIVER
ADVANCED PATIENT NOTICE OF NON COVERAGE

Insurance companies and managed care plans do not pay for every test. In some cases your healthcare provider may have reason to believe that you need this test. We expect that your insurance may not pay for the test for one of the following reasons:

____ Authorization is not received before the procedure is rendered.
____ Authorization was denied by your insurance carrier.
____ Insurance is not showing eligibility for the date of service.
____ Diagnosis may not be considered medically necessary for the procedure performed.
____ Procedure may exceed the frequency standards for this test. For example most insurance plans will only pay for a Screening Mammogram once every 12 months. Bone Density test once every 2 years (unless on osteoporosis drug therapy or steroids) and Carotid Doppler every few years, 1 a year or every 6 months depending on the amount of stenosis or surgical date.
____ Other reason(s) not listed above: _____

LIST PROCEDURE(S) OF REASON CHECKED ABOVE:

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

❑ **OPTION 1.** I want the procedure(s) listed above. You may be asked to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on a Summary Notice. I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance** by following the directions of my plan**.** If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the procedure(s) listed above, but do not bill my insurance. You may be asked to be paid now, as I am responsible for payment. **I cannot appeal if my insurance is not billed**.

❑ **OPTION 3.** I don't want the procedure(s) listed above. I understand with this choice I am **not** responsible for payment**,** and **I cannot appeal to see if my insurance would pay.**

This notice gives our opinion, not an official insurance plan decision. If you have other questions on this notice or insurance billing, call the customer service number on your insurance card.

Signing below means that you have received and understand this notice. You also received a copy.

INSURANCE PLAN NAME: _____

PRINT PATIENT NAME: _____

Signature:	**Date:**