Patient Name:

Medical Record Number:

Notice of Noncoverage

We expect that your health plan will not pay for the item(s) or service(s) that are described below. Your health plan does not pay for all of your health care costs. Your health plan only pays for covered items and services when your health plan's rules are met. The fact that your health plan 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 health care provider to recommend it. However, your health plan may not pay for:

Items or Services:	Estimated Cost:

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 items or services listed above.

OPTIONS: Check only one box; we cannot choose a box for you.

☐ **OPTION 1.** Yes, I want to receive these items or services. I understand that my health plan will not decide whether to pay unless I receive these items or services. Please submit my claim to my health plan. I understand that you may bill me for items or services and that I may have to pay the bill while my health plan is making its decision. If my health plan does pay, you will refund me any payments I made to you that are due to me. If my health plan denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my health plan's decision.

☐ **OPTION 2.** Yes, I want to receive these items or services, but do not bill my health plan. You may ask to be paid now as I am responsible for payment, and that I will not be able to appeal your opinion that my health plan will not pay.

☐ **OPTION 3.** No, I have decided not to receive these items or services. I will not receive these items or services. I understand that you will not be able to submit a claim to my health plan and that I will not be able to appeal your opinion that my health plan will not pay.

This notice gives our opinion, not an official insurance coverage decision. Your health information will be kept confidential in accordance with the Privacy Regulations. If a claim is submitted to your health plan, your health information on this form may be shared with your health plan. If you pay out of pocket in full for a particular healthcare item or service, you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. By signing below, you acknowledge that you have received and understand this notice. You will also receive a copy.

Signature:	Date: