Robert Appling, DPM

5779 Getwell Rd Bldg A Suite 5

Southaven, Ms 38672

(662) 470-5029

ADVANCE BENEFICIARY NOTICE (ABN)

PATIENT NAME: _____

TYPE OF INSURANCE/ID#: _____

DATE OFBIRTH: _____

NOTE: YOU NEED TO MAKE A CHOICE ABOUT RECEIVING THESE HEALTHCARE ITEMS AND/OR SERVICES.

We expect that Medicare, Tenncare type insurance, or any Medicare replacements will not pay for the following item(s) or service(s) that are listed below. Medicare, as well as these other types of insurance only pay for covered items and services when Medicare rules are met. The fact that your insurance MAY NOT PAY FOR A PARTICULAR ITEM OR SERVICE DOES NOT MEAN THAT YOU SHOULD NOT RECEIVE IT. There may be a medical necessity reason your physician has recommended it. Right now, in your case, your insurance will probably not pay for the following types of services/items:

Items/Services: nail trimming, all DME products (ex: boots, shoes, foot/toe splints, foot/ankle braces, etc.) ---- all these items/services given within 2016
Because: These items typically do not qualify as a covered service/ item

The purpose of this form is to help you make an informed decision about whether you would like to receive these items and/or services, knowing that you might have to pay out of pocket yourself. Before you make a decision about your different options, you should read this entire notice carefully.

1. Ask us to explain, if you don't understand why your insurance probably won't pay.
2. Ask us how much each of these services/items may cost you. We can give you an estimated cost depending on your type of insurance and the service/item you may choose to receive, in case you have to pay for them yourself.

PLEASE CHOOSE ONE OPTION ONLY. CHECK/INITIAL THE CORRESPONDING BOX. SIGN&DATE BELOW.

_____ **OPTION 1. YES, I WANT TO RECEIVE THESE ITEMS/SERVICES THE PHYSICIAN HAS RECOMMENDED.** I understand that my insurance will not decide whether to pay until/unless I receive these items or services. Please submit my claim to my insurance. I understand that I may receive a bill for these items/services, and that I may have to pay the bill while my insurance company is making a decision. If my insurance pays, you will refund me any payments I made to you that may be due to me. If my insurance 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 may have. I understand I can appeal my insurances decision. **INITIAL** _____
_____ **OPTION 2. NO, I HAVE DECIDED NOT TO RECEIVE ANY OF THESE ITEMS/SERVICES.** I will not receive any of the above listed items/ services, regardless of my physicians recommendation and/or medical necessity. I understand that you will not be able to submit a claim for these items/services to my insurance, and I will not be able to appeal your opinion that my insurance will not pay. **INITIAL** _____

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SIGNATURE OF PATIENT/RESPONIBLE PARTY **DATE**

NOTE: Your healthcare information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your healthcare information on this form may be shared with Medicare or your insurance company. Your health information which Medicare or your insurance company sees will be kept confidential by your insurance company.