A. Notifier: Ophthalmology Associates, S.C.

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare or your medical insurance doesn't pay for **D. Refraction** listed below, you may have to pay. 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 Medicare or insurance may not pay for the following below.

D. Refraction	E. Reason Medicare May Not Pay:	F. Estimated Cost
CPT code: 92015 Refraction (determines your eyeglass prescription)	If your diagnosis is medical and your vision coverage doesn't cover your medical exam, your medical insurance may cover the exam but not the refraction. (considered routine vision)	$42.00

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. Refraction** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have.

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

☐ **OPTION 1.** I want the **D. Refraction** listed above. You may ask to be pay now, but I also want Medicare or my insurance billed for an official decision on payment, which is sent to me as an EOB (explanation of benefits). I understand that if insurance doesn't pay, I am responsible for payment. If money is collected and insurance **does** pay, a refund of any payments I made, less co-pays or deductibles, will be returned to me.

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

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

This notice gives our opinion, not an official Insurance decision. If you have other questions on this notice or about insurance billing, please ask one of our trained staff members or the administrator.

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

H. Signature:	I. Date:

Patient Name (Printed) _____