

Notifier: MD Pain

P.O. Box 668, Arvada, CO 80001
303-750-8100

EMMI

P.O. Box 668, Arvada, CO 80001
303-422-9438

Patient Sticker

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If your insurance doesn't pay for Anesthesia Services below, you may have to pay. Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. Insurance is anticipated not to pay for the Anesthesia Services below.

Anesthesia Services For:	Reason Your Insurance May Not Pay:	Estimated Cost
Anesthesia services for pain procedure(s).	Insurance may not pay for anesthesia for your pain procedure. Insurance does not consider anesthesia to be medically necessary for pain procedures.	

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 Anesthesia Services listed above.

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

- OPTION 1.** I want the Anesthesia Services listed above. You may ask to be paid now, but I also want the Insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that Insurance does not pay, I am responsible for payment, but I can appeal the insurance by following the directions on the EOB. If insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the Anesthesia Services listed above, but do not bill insurance and have signed an Insurance Waiver. You may ask to be paid now as I am responsible for payment. I cannot appeal if insurance is not billed.
- OPTION 3.** I don't want the Anesthesia Services listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if the insurance would pay.

Additional Information:

Billing questions please contact EMMI at 303-422-9438.

This notice gives our opinion, not an official insurance decision.

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

Signature:

Date: