PEDIATRIX
Medical Group
Part of the Mednax® Family

Advanced Beneficiary Notice (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that the specified payer **will not pay** for the item(s) or services (s) described below. The fact that the specified payor 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 doctor recommended it.

We expect the payer will probably not pay for:

Items or Services: ____

____

Reason: ____

____

Estimated Cost:____

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us to explain any questions you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.

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

PLEASE CHOOSE ONE **OPTION. CHECK** ONE **BOX.** SIGN & DATE **YOUR CHOICE.**

☐ Option 1. YES. I want to receive these items or services.

I understand I may be asked to be paid now, but I also want the specified payor billed for an official decision on payment. **I understand that if the specified payor does not pay, I am responsible for payment, but I can appeal the payor's decision**. If the specified payor does pay, you will refund to me any payments I made to you that are due to me, less co-pays or deductibles. **If the specified payor denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through other insurance that I may have**.

☐ Option 2. YES. I want to receive these items or services, but do not bill the specified payer.

I understand with this choice I am responsible for payment and I cannot appeal to see if the specified payer would pay.

☐ Option 3. NO. I have decided not to receive these items or services.

I understand with this choice I am not responsible for payment, and I cannot appeal to see if the specified payer would pay.

____

Date Signature of patient or person acting on patient's behalf

NOTE: Your health 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 the specified payer, your health information may be shared with the specified payer. The specified payer will keep your health information confidential.