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Advance Beneficiary Notice for Non-Covered Services

Patient's Name: _____ Date: _____

Your insurance does not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your provider believes that the following service(s) are an important part of your mental health care and recommends that you receive these services as part of your current treatment plan. If you choose to receive these services, we will submit a claim to your insurance on your behalf, but if the service is denied, you will be personally responsible for the payment of services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these services.

The services recommended by your physician are listed below:

_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

The total cost for the services/items recommended by your physician are:

$_____

I acknowledge that I have been informed in advance of receiving these services, that these services may not be covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Patient Signature _____

Date_____