Patient's Name:

_____

Advanced Beneficiary Notice (ABN)

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

We expect that your insurance carrier will not pay for the item(s) or service (s) that are described below. Your insurance carrier does not pay for all of your health care costs. Your insurance carrier only pays for covered items and services when your insurance carrier's rules are met. The fact that your insurance carrier 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. Right now, in your case, **your insurance carrier probably will not pay for-**

Items or Services:

1. Intravitreal injection of Avastin
2. Cost of drug: $150.00

Because:

These services may not be covered by your insurance carrier.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why your insurance carrier probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost:** $35 to $100).

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

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

I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance company is making its decision if it does pay, you will refund to me any payments I made to you that are due to me. If my insurance carrier 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 have. I understand I can appeal my insurance carrier's decision.

_____**Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to your insurance carrier that I will not be able to appeal your opinion that your insurance carrier won't pay.

_____ _____

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