Tri-County Medical & Ostomy Supplies, Inc.

COMMERCIAL INSURANCE ADVANCE BENEFICIARY NOTICE

PATIENT'S NAME _____

INSURANCE COMPANY _____ (Plan)

We expect that the above named insurance plan will not pay for the products/ supplies that are described below. The plan does not pay for all of your health care cost. The plan only pays for covered items and services when the plan's rules are met. The fact that the plan 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 has recommended it.

Items/supplies to be received:

Your insurance may or may not cover these items indicated below for the following reasons:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these supplies, 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 the plan probably won't pay. Your cost for these items or supplies will be:$_____in case you have to pay for them yourself or through other insurance plans.

Please circle yes or no below to signify your choice

Please sign and date this form below to attest your choice

- **YES I want to receive these tests/supplies**

I understand that my plan will not decide whether to pay unless I receive these tests/supplies. Please submit my claim to my plan. I understand that you may bill me for tests/supplies and that I may have to pay the bill while my plan is making its decision. If my plan 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 that I can appeal my plans decision.

- **NO I have decided not to receive these tests/supplies**

I will not receive these items/supplies. I understand that you will not be able to submit a claim to my plan and that I will not be able to appeal your opinion that my plan won't pay. I will notify any referral doctor who ordered these tests/supplies that I did not receive them.

_____ _____

Signature patient or person acting on Patient's behalf Date