Garrison Family Medical Group

A. Notifier: Garrison Family Medical Group Providers:R Garrison MD, T. Tanner PA-C, D. Rice FNP, T "J" Wheaton FNP, S. Robertson FNP

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If your insurance doesn't pay for **D.** Telemedicine Visit below, you may have to pay.

Your insurance may not offer coverage for the following services even though your health care provider advises these services are medically necessary and justified for your diagnoses.

We expect your insurance may not pay for the **D.** Telemedicine Visit below.

D.	E. Reason Insurnance May Not Pay:	F. Estimated Cost
Telemedicine Visit with Garrison Family Medical Group Provider (R. Garrison, MD; D. Rice, FNP; T. Tanner, PA-C; T "J" Wheaton, FNP, or S. Robertson, FNP) via GFMG.doxy.me for purposes of routine followup care, illness, injury, pandemic concerns, or other health concerns that would typically be treated via face-to-face visit in the office.	If your insurance does not consider telemedicine appropriate for your current concern, they may not pay. (From 3/18/20 through 5/18/20, this is not likely as Medicare has waived all exclusions andneed for priorauthorizations for telemedicine visits).	$45 You will be charged $65 prior to the Telemedicine Visit. If your insurance does not pay their portion, you will be charged an additional $45 bringing the total to $110 which is the standard rate for an office visit.

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 **D.** Telemedicine Visit as above.
  Note: If you choose Option 1 or 2, we may help you to appeal to your insurance company for coverage

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.** Telemedicine Visit listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me as an Explanation of Benefits. I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance company.** If my insurance company does pay, you will refund any payments I made to you, less co-pays, deductibles, or charges by Stripe.
☐ **OPTION 2.** I want the **D.** Telemedicine Visit listed above, but do not bill my insurance company. You may ask to be paid now as I am responsible for payment
☐ **OPTION 3.** I don't want the **D.** Telemedicine Visit listed above. I understand with this choice I am **not** responsible for payment.

H. Additional Information:

This notice gives our opinion, not a denial from your insurance company. If you have other questions on this notice please ask the front desk person, the billing person, or the physician before you sign below.
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Created 3/18/20