OVERLAKE ARTHRITIS & OSTEOPOROSIS CENTER, PLLC
2100 116th Ave NE Bellevue, WA 98004 Ph: 425-453-0766 Fax: 425-451-3560

ADVANCED BENEFICIARY NOTICE (ABN) FOR DEXA

NOTE: You need to make a choice about receiving these services.

We expect that your health care plan may not pay for the services that are described below. Your health care plan does not pay all of your health care costs. It will only pay for covered items and services that meet their rules, guidelines, and contract specifications. The fact that your health care plan may not pay for a particular item or service does not mean that you should not have it. There may be a good reason your doctor recommended it. Right now, in your case, _____ **may not pay for the service(s) indicated for the following reasons:**

- Does not pay for these tests as often as this (denied as too frequent per plan)
- Does not pay for osteoporosis screening (DEXA) in male patients
- Medicare and some insurances will not pay for an annual exam and/or DEXA

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

- Ask us to explain, if you don't understand why your insurance may not pay for:
  DEXA Osteoporosis Screening
- **ESTIMATED COST: $ 280.72**

PLEASE CHOOSE **ONE** OPTION THEN **SIGN AND DATE** YOUR CHOICE:

☐ **Option 1: YES. I want to receive these services.**

I understand that my health care plan will not decide whether to pay unless I receive these services. Please submit my claim to my health care plan. I understand that you may bill me for services and that I may have to pay the bill while my health care plan makes its decision. If my health care plan does pay for these services, I will be refunded any payments I have made to you that are due to me for these services. If my health care plan denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally out-of-pocket or through any other insurance I may have. I understand I can appeal my health care plan's decision.

☐ **Option 2: NO. I have decided not to receive these services.**

I will not receive these services. I understand that you will not be able to submit a claim on my behalf to my health care plan and that I will not be able to appeal your opinion that my health care plan may not pay.

Today's Date Signature, above