MIDWEST EYE CARE PC / MIDWEST EYE SURGERY CENTER LLC

MEC Tax ID:470805428 NPI:1750360897 / MESC Tax ID:470831193 NPI:1598744732

4353 DODGE ST OMAHA, NE 68131

Patient's Name: DOB: Account Number:

Advanced Beneficiary Notice

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

Your insurance may not pay for all of your health care costs. Your insurance only pays for covered items and services when their rules are met. The fact that your insurance 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 will probably not pay for:

Items or Services: Eye Exam

Date of Services:

Because:

_____ I chose to see the doctor of my choice and did not get a referral
_____ The doctor is not a participating provider
_____ The services/supplies are not a covered benefit
_____ Insurance card not available at time of service
___X_ Other – You are listed as self pay due to no insurance on file. If you have insurance coverage please upload a copy or bring a copy of your card(s) to your appointment.

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 won't pay.
- Ask us how much these items or services will cost you (up to $389.00 for an exam. This does not include testing or other treatment performed). This is an estimate only, if your insurance does not pay you may be responsible.

❑ YES. I want to receive these items or services.

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

_____ _____

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