M. A. Khan, M.D.
Board Certified Dermatologist
Tel: 330-492-11117
Fax: 330-244-9451
www.makhanmd.com

Patient Name: ____ **Date:** ________________

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Health Plan doesn't pay for the *Service* listed below, you may have to pay.

Health Plan does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Health Plan may not pay for the ***Service*** listed below.

Service	Reason Health Plan May Not Pay	Estimated Cost
❑ Routine Office Exams & Skin Cancer Screenings ❑ Routine removal of skin tags, blemishes, moles, warty growths etc	May be considered Medically Unnecessary by your Medical Insurance Plan	

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 ***Service*** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your Health Plan cannot require us to do this.

OPTIONS: **Check only one box and Initial. We cannot choose a box for you.**

❑ **OPTION 1.** I want the ***Service*** listed above. You may ask to be paid now, but I also want Health Plan billed for an official decision on payment, which is sent to me on a Health Plan Summary Notice. I understand that if Health Plan doesn't pay, I am responsible for payment, but **I can appeal to my Health Plan.** If my Health Plan does pay, you will refund any payments I made to you, less co-pays or deductibles. **Initial:** ______

❑ **OPTION 2.** I want the ***Service*** listed above, but do not bill Ins Plan. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Ins Plan is not billed**. **Initial:** ______

❑ **OPTION 3.** I don't want the ***Service*** listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Ins Plan would pay.** **Initial:** ______

Additional Information: **You may ask your Health Plan for a pre-approval letter.**

This notice gives our opinion, not an official HEALTH PLAN decision. If you have other questions on this notice or your Health Plan billing, please call the number on your Health Plan Summary Notice.
Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**