

Patient's Name: _____

Insurance Co: _____

Advance Beneficiary Notice (ABN)

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

Your health insurance may not pay for the item(s) or service(s) that are described below. Health insurers do not necessarily pay for all of your health care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular service does not mean that you should not receive it, your doctor recommends that you do receive this service.

Item(s) or Service(s): VISION SCREENING PROCEDURE 99173

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. Also, by signing below you agree to take financial responsibility for the cost of the item(s) or service(s), if your health insurance does not include this as a covered item(s) or service(s). **The cost for vision screening is \$23.00.**

Responsible party signature: _____

Date: _____