YUILL BLACK, M.D. AND MICHAEL R. KLETZ, M.D., P.C.

MICHAEL R. KLETZ, M.D., F.A.A.A.A.I., F.A.C.A.A.I., F.A.C.P.
APPAJI GONDI, M.D.

Advance Beneficiary Notice of Noncoverage (ABN)

Patient Name: _____

Date of Birth:_____ Account #:_____

Note: Your health insurance company may not cover all or pay for all of your health care costs. Your insurance company only pays for ***covered*** items and services when your insurance company rules are met. **Your health insurance company may or may not pay for the following services or items. Prior verification of benefits is not a guarantee of payment. Please refer to your benefits manual for detailed information about your individual coverage.**

Services provided:

- Office visit/Consultation
- Environmental/Food/Venom and/or Drug Allergy Testing
- Pulmonary Services
- Preparation of Allergy Serum
- Allergy Injection
- Patch Testing
- All Xolair and Nucala services or other injection services
- Laboratory and/or X-ray studies
- Other services as necessary

Likely reasons for denial of insurance payment:

- May not pay for this procedure.
- May not pay for procedure on the same day as an office visit.
- May not pay for this test.
- May not pay for this service for this condition.
- May not pay when a specialist provides service.
- Pre-existing condition clause exists. Certificate of credible insurance is necessary.
- No referral/prior authorization for service provided.
- Elect to use out-of-network option for service.
- Failure to provide up to date insurance information.
- Insurance benefits may vary according to the office location where services are rendered.

Beneficiary Agreement

I, _____, acknowledge that I have read the information above and understand that I will be fully responsible for any account balance resulting from both covered (deductible, co-pays and co-insurance) and non-covered services.

_____ _____
Signature of Beneficiary or Person Acting on Behalf of Beneficiary Date

Relationship to patient ☐ Same ☐ Parent/Guardian

_____
Provider Representative