A. Notifier: Kerstin Helgason, NP **C. Date of Birth:**

B. Patient Name:

Advance Beneficiary Notice of Non-coverage (ABN) Medicaid/Insurance

Note: If Medicaid (Medi-Cal)/other insurance doesn't pay for **D. _____** below, you may have to pay for the services.

Medicaid/other insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicaid/other insurance may not pay for the **D. _____** below.

D.	E. Reason Medicaid May Not Pay:	F. Estimated Cost
1.Psychiatric Evaluation 2.Psychiatric medication management (follow-up) 3. Psychotherapy	Provider (Helgason NP) is not in-network with Medicaid (Medi-Cal) and some Secondary insurances, and is not able to bill Medicaid or other out of network insurances for those services.	1. $200-300 2. $85-200 3. $85-200

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 **D. _____** listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicaid cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the **D. _____** listed above. You may ask to be paid now, but I also want Medicaid/other insurance billed for an official decision on payment, which is sent to me on a Medicaid/ other insurance Summary Notice (MSN). I understand that if Medicaid/insurance doesn't pay, I am responsible for payment, but **I can appeal to Medicaid/ insurance** by following the directions on the MSN. If Medicaid does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the **D. _____X_____** listed above, but do not bill Medicaid. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicaid/other insurance is not billed.**

OPTION 3. I don't want the **D. _____** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicaid/other insurance would pay**.

H. Additional Information:

This notice gives our opinion, not an official Medicaid/other insurance decision.

Signing below means that you have received and understand this notice. You may also receive a copy.

I. Signature:	J. Date: