Balloon dilation of the Eustachian tube (BDET)

INSURANCE ADVANCED BENEFICIARY NOTICE (ABN)

BOISE ENT™

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Notifier _____ **Practice** _____

Patient _____ **Address** _____

Date _____/_____/_____

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

We expect that insurance will not pay for the item(s) or services(s) that are described below. Insurance does not pay for all of your health care costs. Insurance only pays for covered items and services when insurance rules are met. The fact that 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, insurance probably will not pay for:

Items or services _____

because _____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or service, knowing that you might have to pay for them yourself. Before you make any decision about your options, you should:

- Read this entire notice carefully
- Ask us to explain if you don't understand why insurance probably won't pay
- Ask us how much these items or services will cost you in case you have to pay for them yourself or through other insurance

Please choose one option and initial your choice

☐ **Option 1**
Yes, I want to receive these items or services.

I understand that insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. 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 a decision. If insurance does pay, you will refund me any payments I made to you that are due to me. If insurance denies payment, I agree to be person-ally 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's decision.

Initial: _____

☐ **Option 2**
No, I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that insurance won't pay.

Initial: _____

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

Date _____ **Signature** _____