Patient Name: *Visit Ticket #*:

Notice of Non-covered Service

*NOTE:* If your insurance does not pay for the *condition & procedure* below, you may have to pay.

Insurance does not pay for everything, even some care that you or Dr. Miller have good reason to think you need. We expect insurance may not pay for the *condition & procedure* circled below.

|  |  |  |
| --- | --- | --- |
| **Treatment of the following:** | **Reason Insurance May Not Pay:** | **Estimated Cost:** |
| **Seborrheic keratosis** (CPT 17110)  **Wart**  (CPT 17110)  **Cyst** (CPT 11300-11443)  **Skin tag** (CPT 11200)  **Benign neoplasm** (CPT 11300-11443) | Insurance does not pay for this condition  Insurance does not pay for this condition  Insurance does not pay for this condition  Insurance does not pay for this condition  Insurance does not pay for this condition | $\_\_\_\_\_\_\_\_\_\_\_  $\_\_\_\_\_\_\_\_\_\_\_  $\_\_\_\_\_\_\_\_\_\_\_  $\_\_\_\_\_\_\_\_\_\_\_  $\_\_\_\_\_\_\_\_\_\_\_ |

**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 *treatment* listed above.

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| **Options: Check only one box. We cannot choose a box for you.** |
| **❏ OPTION 1.** I want the ***procedure*** circled above. I will pay for the service today, but I also want my Insurance billed for an official decision on payment. I understand that if my insurance doesn’t pay, I am responsible for payment. If my Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.  **❏ OPTION 2.** I want the ***procedure*** circled above, but do not bill my Insurance. 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 my insurance won’t pay. I am responsible for payment and will pay for the service today.  **❏ OPTION 3.** I don’t want the ***procedure*** circled above. I understand with this choice  I am not responsible for payment, and I will not receive the procedure. |

By signing below, you acknowledge you have received and understand this notice.

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| **Signature:** | **Date:** |