THE VISION CENTER

COMMERCIAL INSURANCE ADVANCED BENEFICIARY NOTICE

PATIENT'S NAME _____

INSURANCE COMPANY _____ (PLAN) _____

We expect that the above-named insurance plan will not pay for the products/supplies that are described below. The plan does not pay for all of your health care cost. The plan only pays for covered items and services when the plan's rules are met. The fact that the plan 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 has recommended it.

Items/supplies to be received that your insurance may or may not cover:

1) Refraction: Medicare, Humana, Blue Cross, and all other medical insurances do not cover.
2) Special Testing: Medical insurance will cover - Vision will not cover.
3) Frames / Specialty Frames: Medical insurances do not cover - Vision may cover with additional co-pay.
4) Lenses / Specialty Lenses: Medical insurances do not cover - Vision may cover with additional co-pay.
5) Contacts Lenses: Vision will not cover if glasses ordered. Medical insurance does not cover.
6) Contact Lens Fit Fee: Vision insurance will cover in lieu of contacts.
7) Allowance Overages: Not all secondary insurances cover.
8) Co-Pays: Not all secondary insurances cover.
9) Deductibles: Medical will apply but patient may still owe. Some secondary insurances do not cover.
10) Accessories: Not covered by insurance.
11) Solutions / Drops: Not covered by insurances.
12) Refiling of Insurance: If claim is denied there is a $25.00 refiling fee.
13) Postage: If you choose to have glasses/contacts sent directly to you.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these supplies, knowing that you might have to pay for them yourself. **Before you make a decision about your options, you should read this entire notice carefully.**

Ask us to explain if you don't understand why the plan may not pay for the services. We will gladly explain the cost of these items so you have a full understanding of what to expect upon check out.

- **Please check YES or NO below to signify your choice**
- **Please sign and date this form below to attest your choice**

❑ **YES** I want to receive these tests/ supplies.
Please submit my claim to my plan. I understand you may bill me and that I may have to pay the bill while my plan is making its decision. If my plan denies payment, I agree to be personally 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 that I can appeal my plans decision with the insurance company.

❑ **NO** I have decided not to receive these tests/supplies.
I will not receive these items/supplies. I understand that you will not be able to submit a claim to my plan and that I will not be able to appeal your opinion that my plan won't pay. I will notify any referral doctor who ordered these tests/supplies that I did not receive them.

_____ _____

Signature of Patient or Parent/Guardian Date

_____

Patient Name (PRINTED)

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