THE University of Vermont HEALTH NETWORK

ADVANCE NOTICE OF POTENTIAL NON-COVERAGE BY A COMMERCIAL INSURER

Patient Billing: 802-847-8000 or
Toll-Free: 800-639-2719
Lab Inquiries: 802-847-5121

FOR PATIENTS WITH COMMERCIAL INSURANCE ONLY – NOT FOR PATIENTS WITH MEDICARE/MEDICAID/TRICARE

THIS SECTION IS TO BE COMPLETED BY OFFICE STAFF ONLY

_____
Patient Name / Medical Record Number (MRN)

_____
Medical Service Description / CPT Code Number(s)

_____
Treating Physician / Site of Service / Telephone Number

_____
Commercial Insurance Carrier / Plan Title or Number / Member ID Number

_____
Estimated Cost

You have been scheduled to receive the medical service(s) specified above. Health insurance doesn't pay for everything, including some services your health care provider has good reason to think you need. The University of Vermont Medical Center believes your health insurance carrier might consider the above service(s) to be experimental, investigational, or not medically necessary, according to the terms of your insurance policy. **If your insurance carrier considers the above service(s) to be experimental, investigational, or not medically necessary, it will not pay benefits for the service, and you will be personally responsible for paying the bill.**

WHAT YOU NEED TO DO NOW:

1. **Read this Notice very carefully so that you can make an informed decision about your health care.**
2. **Ask us any questions that you may have after you finish reading.**
3. **Choose one of the options by initialing in the box next to your selection.**

☐ **OPTION 1:** I want the service(s) listed above even though I may be personally responsible for paying for them. I want my health insurer billed for an official decision on payment. I understand that if my insurer considers the service(s) to be experimental, investigational, or not medically necessary, and refuses payment for the service(s) in whole or in part, I am personally responsible for paying any unpaid portion of the bill. The University of Vermont Medical Center reserves its right to collect anticipated patient responsibility at the time of service.

☐ **OPTION 2:** I want the service(s) listed above, but do not bill my health insurer. I will be responsible for paying now, at the time of service, and I understand that by choosing this option, I cannot appeal or reverse my decision to self-pay for the service(s).

☐ **OPTION 3:** I don't want the service(s) listed above. I understand that with this choice I am not responsible for payment and I cannot appeal to see if my health insurer would pay.

I certify that I carefully read this Advance Notice of Potential Non-Coverage and fully understand its contents. I understand this Advance Notice of Potential Non-Coverage is legally binding and that my signature below verifies that I chose the option indicated above knowingly, freely and voluntarily.

_____ _____
Patient Signature **Date/Time** **Witness Signature** **Date/Time**

_____ _____
Print Patient Name **Print Witness Name / Employer and Title**