Advance Beneficiary Notice (ABN)
Surgical Procedures

Note: You need to make a choice about receiving this healthcare service.

I understand that my insurance company may not pay for this service for several reasons, and not limited to:

- Not a covered benefit
- Applied to the yearly deductible
- Absence of an insurance approved authorization
- Not medically necessary
- Pre-existing condition insurance clause

Please submit my claim to my insurance company. I understand that I am responsible for any services that are denied by my insurance company.

Print Name: _____

Signature: _____ Date: _____