Internal Medicine Primary Care Physicians

42557 Woodward Ave. Suite 110 Bloomfield Hills MI, 48304-5038
Tel: 248.253.1468 Fax: 248.253.1472

Advanced Beneficiary Notice of No coverage (ABN)

Date: _____ Patient Name Printed: _____

Commercial Insurance name: _____

You are receiving this notice because your insurance company may not pay for all of the services that you receive during your visit to our office.

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask any questions that you may have after you finish reading.
- Choose an option below about whether to receive medical care.

____ Yes I want to receive these any/all services. If my commercial insurance carrier denies payment I am completely responsible for payment in full. I understand that I can appeal this decision for nonpayment by my insurance carrier.

____ No I have decided not to receive these services.

____ OTHER Should I decide to request these services in the future, I understand I will be charged and am responsible for payment in full.

By signing this notice I agree to take financial responsibility for the cost of the supplies and services listed above should my insurance company deny coverage for any items.

_____

Guarantor Signature Date

Thank you for your cooperation:
Timothy Lamb M.D.
Varsha Revankar M.D.