

Non-Medicare Advance Beneficiary Notice

Patient Name: _____

Medical Record #: _____

Practice Representative/Witness: _____

Agreement to Pay in Full if Insurance Does Not

***NOTE:** If your insurance company doesn't pay for the services listed below, you will be financially responsible for the total amount due. It is our experience that many insurances will not cover these services.*

Services your insurance may not pay for	Reason your insurance may not pay	Estimated Cost
Traumeel/Zeel intra-articular injection solution for osteoarthritis of the knee	The solution may not be a covered benefit.	

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 services listed above.

Signing below means you have read this notice and are declining this service.

Signature:	Date:
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Signing below means you have read this notice, want to receive this service, and agree to be financially responsible for the full cost of the service in the event insurance does not pay for it.

Signature:	Date:
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