United Anesthesia Services, P.C.

Dear Patient:

You are scheduled to have a procedure done with United Anesthesia Services, PC that requires you to have anesthesia, or your physician has recommended you have anesthesia for your procedure. Before your services are performed, you may be asked to sign an Advanced Beneficiary Notice or "ABN".

Included below are answers to some of the questions you may have about the ABN and why you are being asked to sign it.

What is an Advanced Beneficiary Notice or "ABN"?
An ABN is a form that lets you know that you may have to pay for a service the provider will render if your insurance carrier refuses to pay for it. The ABN helps you to make an informed decision about whether to obtain the service and pay for it, or choose not to receive it.

Why don't you think my insurance will pay for this service?
Most insurance carriers pay only for services that they consider to be medically necessary. The medical necessity requirements vary from one carrier to another.

I have not had to pay for this service before. Is this something new?
The ABN is not new – it has been around for ten years. There have been recent changes in how insurance carriers pay for different services, and these changes make it more likely that your insurance carrier may not pay.

Why do you want me to sign the ABN?
If you receive an ABN that means that we expect that your insurance may not pay for your services. We ask patients to sign an ABN whenever it appears the insurance carrier is likely to deny payment for the specific service. This provides documentation that we have notified you that you will likely be responsible for the bill.

Please feel free to contact the number listed below should you have any questions.

1-800-242-1131, Ext 4172

Thank you,

United Anesthesia Services

Please complete and sign the form on the back of this letter.

610 West Germantown Pike, Suite 150 Plymouth Meeting, PA 19462
Office: 610-525-4966 - Fax: 610-525-0874

Independence

Member Consent for Financial Responsibility for Unreferred/Non-covered Services

Member Information

Member Name ________________________________

Member's ID # ________________________________

Provider Information

Provider Name ________________________________

Provider's ID # ________________________________

Specialty or Department ________________________________

Type of Service ________________________________

Member must complete this section

As a member of:
(Circle one)

Keystone Health Plan East (HMO)
Keystone 65 (HMO)
Other ________________________
Personal Choice® (PPO)
Personal Choice℠ 65 (PPO)

I understand that...
(Check the appropriate box):

- ☐ A referral from my Primary Care Physician is required for any and all non-Emergency outpatient hospital/specialist services. I acknowledge that I do not have a referral with me at this time, but I choose to receive the services without the required referral. I understand that without the appropriate referral, I will be held responsible for any payments incurred for these services. (HMO)
- ☐ I understand that this is a noncovered service for which my insurance carrier will not make payment and I agree to be financially liable for any payments incurred for these services. I understand that I have the right to appeal this determination. (ANY) The price for anesthesia care is $225.00 expected prior to time of service.
- ☐ I understand that certain services will only be covered by my insurance carrier when performed by designated providers or in certain settings (e.g., capitated radiology or lab services, and DME services). I understand and agree that I will be financially responsible for certain services that I choose to receive from the provider noted above rather than the designated network provider or in the appropriate setting. The provider has specifically explained to me the services for which I will be financially responsible. (ANY)
- ☐ I understand that I will be responsible for all fees incurred if this visit or any other service precedes the effective date that has been assigned to my enrollment or my dependent's enrollment. (ANY)

________________________________ ________________________________
Member's signature *Employer name (if applicable)*

________________________________ ________________________________
Date *Employer address (if applicable)*

________________________________ ________________________________
Witness / office staff *City* *State* *ZIP*

Independence Blue Cross offers Medicare Advantage plans with a Medicare contract. Enrollment in Independence Medicare Advantage plans depends on contract renewal.

Independence Blue Cross offers products directly through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

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