



2434 Interstate Plaza Drive  
Hammond, IN 46324  
877-937-2190

### Anthem BC Advance Beneficiary Notice

Patient Name \_\_\_\_\_ Patient Number \_\_\_\_\_  
Payor \_\_\_\_\_ Date of Notice \_\_\_\_\_

Payor will only pay for services that it determines to be reasonable and necessary under Anthem BC regulations OR medically necessary under the applicable Payor policies.

If Payor determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under Anthem BC Standards OR “not medically necessary” under the applicable Payors standards, Payor will deny payment of that service. I believe that in your case, Payor is likely to deny payment for the following service(s) for the following reason(s):

Description of Services likely to be denied	Reason For Denial	Approximate Cost

#### **Beneficiary Agreement to PAY**

“I have been notified by my physician/ supplier that in it believes, in my case, Payor is likely to deny payment for the services identified above, for the reasons stated. I understand that I have the right to decide whether or not to receive the serviced identified above. I have decided to receive service. If Payor denies payment, I agree to be personally and fully responsible for payment.”

Patients Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

#### **Beneficiary Refusal to Receive Item or Service at Own Expense**

“I have been notified by my physician/ supplier that it believes that, in my case, Payor is likely to deny payment for the item or service identified above. For the reasons stated above, I have decided not to receive this item or service identified above. I have decided not to receive the item or service, since I am not willing to be personally responsible for payment.”

Patients Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_

#### **Patient refused to sign the Advance Beneficiary Notice (ABN) after reading:**

Witness \_\_\_\_\_ Date \_\_\_\_\_