St. Clair County Community Mental Health Authority

Advance Beneficiary Notice of Non-Coverage (ABN)

Individual: _____ **Case #:** _____ **Date:** _____

NOTE: If your insurance does not provide coverage for services listed in section **"A"** below, you may be required to pay.

_____ may not offer coverage for the below listed services regardless of if your health care
(Name of Insurance provider)
provider advises them to be medically necessary/justified due to your medical diagnosis.

A. Service	B. Reason Insurance May Not Pay:	C. Estimated Cost of Service
☐ 90791 (Intake Code) ☐ T1017 Case Management ☐ H0038 Peer Support Services ☐ T1002 Nursing Services ☐ H2015 Mental Health Assistant ☐ Other: _____		

Total monthly maximum liability: $ _____

After reading the information provided, please choose an option below regarding your decision about your care.

OPTIONS: Select **only** one option. *WE cannot select an option for you*.

◯ OPTION 1- I want the service(s) listed in section **"A"** and I understand I am responsible for payment and may be asked to pay at the time services are rendered.

◯ OPTION 2- I **do not** want the service(s) listed in section **"A".** I understand that with this choice I am not responsible for payment and **will not** receive the listed service(s)

Additional Information:
This notice is a reflection of the estimated insurance coverage experienced by our Agency. **It is not a denial from your insurance company.** If you have any questions regarding this notice, please reach out to your case holder before you sign below.

This fee may be waived if you receive Medicaid or reduced if you qualify for Sliding Fee Scale

_____ _____
Individual Signature Date

Finance Form: #07-0275
Revised Date: 4/09/2024
Policy Ref: #02-001-0025
EHR: Administrative/Financial, Insurance Policies/Funding Sources *Attach as Self Pay Supporting Documentation

EXISTING CASES ONLY

Any **reduction in services** to this case, (i.e. the selection of **OPTION 2** and possibly OPTION 1, if some of the services are continued) the **CASE HOLDER MUST** make the changes below to the individuals' record:

- □ Update Authorizations
- □ Generate an Amendment
- □ Generate an ABD

_____	_____	_____
Case Holder Signature/Credentials	Case Holder Print Name	Date

The Individuals record has been reviewed by the supervisor and the above tasks have been completed.

_____	_____	_____
Supervisor Signature/Credentials	Supervisor Print Name	Date

****For General Fund Requests - Forward this document, along with a completed General Fund Request Form (#03-0368) to your program's Assistant Division Director.**

Finance Form: #07-0275
Revised Date: 4/09/2024
Policy Ref: #02-001-0025
EHR: Administrative/Financial, Insurance Policies/Funding Sources *Attach as Self Pay Supporting Documentation