St. Clair County Community Mental Health

Advance Beneficiary Notice of Non-Coverage (ABN) for SUD Services

Individual: ____ Case #: ________________ Date: ___________________

NOTE: If your insurance does not provide coverage for the 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
☐ H0038 Self Help/Peer Services		
☐ 9083X Individual Therapy Bundle		
☐ H0006 Case Management		
☐ H0004 Behavioral Health Counseling & Therapy		
☐ 90853 Group Therapy		
☐ T1007 Treatment Plan Development/Modification		
☐ 9079X Psychiatric Diagnostic Evaluation Bundle		
☐ 992XX Medication Review Bundle		
☐ 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 the Sliding Fee Scale.

_______________________________________ _______________________________________ ____________

Individual Signature Print Name Date

Finance Form: #07-0275
Revised Date: 7/1/2024
Admin Procedure Ref: TBD
EHR: Administrative/Financial, Insurance Policies/Funding Sources *Attach to Self-Pay Policy as Supporting Documentation

EXISTING CASES ONLY

In the event, there is **any** reduction in services to this case (i.e., selection of Option 1 if the individual agrees to a reduction in services, the selection of Option 2, etc.), then the Case Holder **MUST** make the changes below to the individual's record in order to reflect the reduction in services:

☐ Update Authorization(s)

☐ Generate an Amendment

☐ Generate an Adverse Benefit Determination Notice (ABD)

_______________________________________ _______________________________________ ____________

Case Holder Signature/Credentials Print Name Date

The individual's record has been reviewed by the Supervisor and the above tasks have been completed.

_______________________________________ _______________________________________ ____________

Supervisor Signature/Credentials Print Name Date

****For General Fund Requests:** Forward this completed document, along with a completed General Fund Request form (#03-0368) to your Program's Service Director.