Notifier: Creative Development, LLC
30 Avon Meadow Lane
Avon, CT 06001
860-284-9779

Important Information
To be completed by the Insured/Guarantor

Client Name:_____

TO CURRENT AND POTENTIAL CLIENTS

Advanced Beneficiary Notice of Non-coverage (ABN)

NOTE: Your Insurance plan _____ may not provide coverage for the skilled services of **OT / PT / SLP** . If your insurance does not provide coverage/payment for **OT / PT / SLP** you may be responsible. Your insurance plan may not provide coverage for the following services even though your health care provider advises these services are medically necessary and justified for your child's diagnoses.

Services (Circle all that Apply)	Reasons Insurance May Not Pay:	Estimated Cost
Occupational Therapy Physical Therapy Speech Therapy	Not Medically Necessary Not a COVERED BENEFIT on member's plan Visit limit met for year	**$__150.00/hour**

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 **OT / PT / SLP** listed above.
  Note: If you choose Option 1 or 2, we may help you to appeal to your insurance company for coverage.

OPTIONS: Check only ONE box. We cannot choose a box for you.

□ **OPTION 1.** I want the skilled **OT / PT / SLP** listed above.

I want my insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance doesn't cover the services, I am responsible for payment, but I can appeal to _____ by following the directions on the EOB. If _____ does cover my services, I will be refunded any payments made for the dates of service covered, less co-pays or deductibles.

□ **OPTION 2.** I want the skilled **OT / PT / SLP** listed above, but do not bill my insurance _____. I am aware that I will be financially responsible for payment at the time of service.

□ **OPTION 3.** I decline skilled services **OT / PT / SLP** . I no longer choose to receive services (evaluation/treatment) and am therefore not financially responsible.

H. Additional Information:

This notice gives our opinion, not a denial from your insurance company. If you have other questions on this notice please ask one of our billing persons or Directors, before you sign below. Signing below means that you have received and understand this notice. You may request a copy of this notice.

I. Signature:	J. Date: