Dr. Leann Johnson
Board Certified Audiologist
Northern Colorado's Premier Hearing Healthcare Professional

Notice of Non-Coverage – Patient Financial Responsibility

Patient Name: ____ Date of Notice: ___________________

Patient Insurance Provider: ________________________________ Member ID: ____________________

Your insurance provider will only pay for services they determine to be medically reasonable and necessary under their applicable health insurance policies and guidelines, or that which are covered benefits within your current individual and/or family insurance policy. Insurance providers do not pay for every item and/or service requested by a patient or recommended by their audiologist. We have determined, in this case, your insurance provider may or may not pay for the following item(s) or service(s) for the following reason(s):

Hearing Evaluation Advance Beneficiary Notice

Service Likely to be Denied	CPT Code	Reason for Non-Coverage or Denial	Approximate Patient Out-of-Pocket Cost
Comprehensive audio and speech recognition	92557	Typically Covered and/or applied to deductible	$65.00
Tympanometry and Reflex	92550	Typically Covered and/or applied to deductible	$30.00
Comprehensive Diagnostic Evaluation with Report	92588	Typically Covered and/or applied to deductible	$100.00
Hearing Aid Consultation		**Non-Covered/Non-Billable**	$100.00
Tinnitus Consultation		**Non-Covered/Non-Billable**	$100.00
		Total Cost of Full Diagnostic Evaluation Billed to Insurance	**$195.00**
Due at Time of Service		**Total Cost of Non-Billable Services**	**$100.00**

Beneficiary Agreement to Pay:

I have been notified by my audiologist, Dr. Leann Johnson, that it is possible my insurance provider listed above may deny payment for some or all the item(s) and or service(s) identified on this notice.

◯ **I wish for services above to be rendered and for Windsor Audiology to bill to the insurance listed above.** I understand that if services are not covered or **only partially paid for** by the insurance listed, then I will be responsible for payment. I have the right to appeal to my insurance provider and if they do make payment, I will be refunded the amount paid by insurance.

◯ I DO NOT wish for Windsor Audiology to bill the insurance listed above and accept full financial responsibility for all my services the day they are rendered.

Patient Signature: ____ Date Signed: ___________________