Chicago Family Asthma & Allergy, SC
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(773) 388-2322 Fax (773) 388-2333

Advanced Beneficiary Notice (ABN)

- Most services we provide are "covered" by insurance policies. They are supported by good standards of care.
- Insurance companies may not pay for some procedures or medical services, even those that you or your health care provider think you need.
- We apologize that we are not able to verify coverage amounts for your specific policy prior to your visit.
- You are responsible for billed amounts that are not covered by insurance OR that are covered but a balance is applied to your deductible expense policy.

To help you make an informed decision about your care and the services provided, **please read the following information**. You have the option, before providing consent, to verify with your insurance if a procedure or service is covered by your insurance plan. Refer to billing codes listed. For procedures that require multiple "units" for tests, such as for skin tests, you may ask if there is a limit to units covered per day.

Description of procedure or service (estimated cost usually reduced by insurance adjustments):

* Charges are typically reduced by insurance when they "adjust" it to their contracted payment.

- **Skin prick tests, airborne or food allergens (most common procedure)**
  - Procedure code **95004**, units billed determined by number of tests performed.
  - Estimated maximum cost **$10 per unit**.
- **Skin intradermal tests, airborne allergens** (only done after pricks if deemed important)
  - Procedure code **95024**, units billed determined by number of tests performed.
  - Estimated maximum cost **$15** per unit.
- **Skin prick and intradermal medication tests (ex. penicillin) – NOT DONE FIRST VISIT**
  - Procedure code **95018**, units billed determined by number of tests performed, usually seven (7) units.
  - Estimated maximum cost **$45 per unit**.
- **Skin prick and intradermal insect venom tests – NOT DONE FIRST VISIT**
  - Procedure code **95017**, units billed determined by number of tests performed.
  - Estimated maximum cost **$20 per unit**.
- **Spirometry (aka pulmonary function testing)**
  - Procedure codes **94010 or 94375**, depending on the complexity of the case.
  - Estimated maximum cost **$65 or 75, respectively**.

Please ask us any questions, if needed, and **initial by your choice of ONE of the following options**:

____ 1. I want the procedure listed above. Bill my health insurance plan.
____ 2. I want the procedure listed above, but do not bill my health insurance plan. I prefer to be billed directly.
____ 3. I do not want the service(s) or the procedure(s) listed above.

By signing below, if you selected option 1 or 2 above, you agree to take financial responsibility for payment for the procedure(s) or service(s), including if your insurance company does not cover payment.

Patient Name: _____ Date of Birth: _____

Patient or Responsible Party Signature: _____ Date: _____