

**ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)**

**Notification of financial liability for services that  
Medicare & Commercial insurance may not cover.**

<b>PROCEDURE/TEST:</b>	<b>REASON MEDICARE &amp; COMMERCIAL INS. DOES NOT PAY:</b>	<b>COST:</b>
• REFRACTION	• Non-covered service • Routine vision portion	• \$45.00
• OCT SCAN	• Non-billable with Fundus Photography (Optomap)	• \$30.00

- 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.

***Signing below means that you have received and understand this notice.***

Signature: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_