

Patient Name: \_\_\_\_\_ Physician Name: \_\_\_\_\_

**Advance Beneficiary Notice (ABN) of potential non-coverage**

**NOTE:** If your insurer doesn't pay for the **SomnoGuard Oral Appliance**, you will be responsible for the fee. Health Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. The SomnoGuard is an FDA cleared device indicated for the treatment of Snoring and Obstructive Sleep Apnea.

**Reasons your insurer may not pay:** Limitations of Insurer specific Medical Policy regarding Oral Appliances covered indications and therapy specifications.

**Recommended Therapy: SomnoGuard AP2** Prefabricated, Custom Fitted Mandibular Advancement Device (Oral Appliance), US FDA 510(k) 061688

**Cost: \$650.00 deposit** (includes Device, Custom Fitting, consultation and initial adjustment)

**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 Oral Appliance therapy.

**Note:** If you choose Option 1 or 2, we may help you to use any insurance that you might have.

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

**OPTION 1.** I want the **SomnoGuard Oral Appliance**. You may ask to have the deposit amount secured now by check or credit card, but I also want my Insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits Notice (EOB). I understand that if my Insurer doesn't pay, I am responsible for payment, but **I can appeal to my Insurer** by following the directions on the EOB. If my insurance does pay, you will not charge the credit card or deposit the check for **the amount paid by the insurer up to and equal to the fee specified above**, less co-pays or deductibles. Any amount paid by my insurer above the deposit amount will not be refunded. I may be responsible for out of pocket expense in addition to the deposit paid only to the amount approved by my insurer and subject to an unmet deductible.

**OPTION 2.** I want the **SomnoGuard Oral Appliance**, but do not bill my Insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurer is not billed.**

**OPTION 3.** I don't want the **SomnoGuard Oral Appliance**. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my Insurer would pay.**

**Additional Information:**

**This notice gives our opinion, not an official health insurance decision.**

If you have other questions on this notice please ask our staff.

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

You also receive a copy.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CC#:** \_\_\_\_\_ **CCV#:** \_\_\_\_\_ **Ex date:** \_\_\_/\_\_\_

**Zip Code:** \_\_\_\_\_ **Check #:** \_\_\_\_\_