RICHARD KIM MEDICINE

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Advance Notice of Non-coverage

Injection of Platelet Rich Plasma, and/or Bone Marrow Aspirate, and/or Lipoaspirate

NOTE: Your Health Benefits Plan does **NOT** pay for this treatment. This is considered an out-of-pocket expense.

Your health benefits plan does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect that your Health Benefits Plan may not pay for the injection of platelet rich plasma, and/or bone marrow aspirate, and/or lipoaspirate under image guidance. The reason your Health Benefits Plan may not pay is because the treatment may be considered experimental, investigational, or unproven for any indication or condition.

The estimated cost of this treatment is $_____.

What you need to do now:

- Read this notice, so that 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 this treatment.

Option: Check 1 option below.

_____ Option 1. I want the treatment(s) listed above. I agree to pay it now, but I want my Health Benefits Plan billed for a formal decision on service coverage and payment unless it has already advised Richard Kim Medicine within the last 30 days that it does not cover or pay for this service. I am responsible for payment, but I may be able to appeal this decision by my Health Benefits Plan by following my Health Benefits Plan's instructions. If my Health Benefits Plan does pay, you will refund any payments I made to you, less co-pays or deductibles.

_____ Option 2. I want the treatment(s) listed above, but do not bill my Health Benefits Plan. You may ask to be paid now, as I am responsible for payment. I cannot appeal if my Health Benefits Plan is not billed.

_____ Option 3. I do not want the treatment(s) listed above. I understand with this choice I am NOT responsible for payment and I cannot appeal to see if my Health Benefits Plan would pay.

This notice gives our opinion, not an official decision by your Health Benefits Plan.

Signing below means you have received and understand this notice, and that you agree to be personally and fully responsible to the facility for all fees for this treatment.

Patient Name: _____

Signature of Patient:

_____ Date: _____

Signature of Parent, Legal Guardian or Healthcare Agent:

_____ Date: _____

Relationship to Patient: _____

I certify that I have witnessed the person whose signature appears above signing this Advance Notice of Noncoverage.

Witness Signature:

_____ Date: _____