

(A) Notifier (s): **James G. Scelfo, MD, PA DBA// Personalized Primary Care**

(B) Patient Name: _____

(C) Identification Number: _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Cigna Health Plans (PPO, HMO and POS) doesn't pay for (D) Yearly Membership Fee to Personalized Primary Care or the amenities listed on the first page of the PPC Membership Agreement below, you may have to pay.

Cigna does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Cigna may not pay for the (D) the yearly Membership Fee to Personalized Primary Care or the amenities listed on the first page of the PPC Membership Agreement below.

| (D) | (E) Reason Cigna Health Plans May Not Pay: | (F) Estimated Cost: |
|---|--|--|
| <i>The yearly Membership Fee to Personalized Primary Care or the amenities listed on the first page of the PPC Membership Agreement</i> | Is a non covered service not paid by any insurance company | Membership Fees Individual Membership \$1,560.00 Couple Membership \$2,600.00 Child <2 \$520.00 Child >2 \$260.00 |

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 (D) listed above.**

| | |
|--|--|
| (G) OPTIONS: Check only one box. We cannot choose a box for you. | |
| <input type="checkbox"/> OPTION 1. I want the (D) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed. | |
| <input type="checkbox"/> OPTION 2. I don't want the (D) listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay. | |

(H) Additional Information:

This notice gives our opinion, not an official Cigna decision. If you have other questions on this notice or Cigna billing, please call Cigna Health Plans.

Signing below means that you have received and understand this notice. You also receive a copy.

| | |
|-----------------------------|------------------------|
| (I) Signature: _____ | (J) Date: _____ |
|-----------------------------|------------------------|

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.