PROVIDER ADVANCE NOTICE TO INSURANCE BENEFICIARY OF MENTAL HEALTH BENEFITS

As a recipient of your mental health insurance benefits (inclusive of Blue Cross/Blue Shield PPO, APS Healthcare, Medicare, etc.), Northern Illinois Counseling Associates, P.C. (NICA) is informing you that some of the services which are recommended by your mental health provider may not be included as a covered benefit under your insurance plan. Furthermore, your insurance company (and/or through its third-party benefits administrator(s)), will pay only for those services that it determines to be "reasonable and necessary" according to its prevailing clinical practice guidelines. If your insurance company (and/or its third party benefits administrator(s)) determines that a particular service, although it might otherwise be covered, is not deemed by them to be a "reasonable and necessary" service under its unique benefits program standards, your insurance company (and/or its third party benefits administrator(s)) will likely limit or even altogether deny reimbursements for that service. *The possibility that your insurance company might not authorize or otherwise deny insurance coverage for recommended services does not necessarily mean that you should not receive it.* The purpose of this notice is to assist you in making an informed choice about whether or not you voluntarily elect to receive those recommended services, listed below, which may not be authorized, fully reimbursed or otherwise covered under your insurance plan, policy or its practice guidelines. Northern Illinois Counseling Associates, P.C. (NICA) is of the opinion that, in your particular case, your insurance company (and/or its third party benefits administrator(s)) is/are likely to limit reimbursements and/or deny payments for the prescribed, recommended and/or optional service(s) below:

[CPT CODE]: 96101 [SERVICE]: Psychological Testing [FEE]: $___________ per unit

[CPT CODE]: 96118 [SERVICE]: Neuropsychological Screening/Testing [FEE]: $___________ per unit

[CPT CODE]: _____ [SERVICE]: ______________________________ [FEE]: $___________ per unit

[Please note: The total number of all testing units needed for the service(s) recommended above is: #________ units. In the event additional units are either clinically indicated and/or requested by you at a later time, written authorization from you (and/or your responsible party, if applicable) will be required before additional service units are rendered].

Furthermore, any limitation and/or denial of payments by your insurance company (and/or its third party benefits administrator(s)) to the insured and/or to the provider, would most likely be due to one or more of the following:

____ 1. Service(s) for the same illness or condition by more than one provider and/or on the same date is/are denied.
____ 2. Your insurance company (and/or its third party benefits administrator(s)) does not pay for this many services in this time period and/or does not pay and/or may not pay for this/these service(s) under your policy or plan.
____ 3. Your insurance plan allows for a maximum number of services which you may have reached or exceeded.
____ 4. Other (specify reason if known) ____

I, ____, am hereby notified by NICA,
[PRINT PATIENT'S NAME]
that they are of the opinion that, in my particular case, my insurance company (and/or its third party benefits administrator(s)) is/are likely to limit reimbursement and/or deny payment for the service(s) specified above and/or for the reason(s) indicated herein. Consequently, if payment is limited and/or denied under these or any other conditions, and if I elect to receive those recommended services, listed above, then I accept full and complete liability for those services NOT paid by my insurance company (and/or its third party benefits administrator(s)) and agree to be fully and personally responsible for all payment, with payment-in-full due at the time services are rendered, consonant with the usual terms of NICA's fee-for-service payment policy. My signature below will attest to my having read, discussed, understood, accepted, elected, agreed to be bound by this notice and authorized the recommended service(s) and fee(s), listed above, voluntarily and without duress.

____ ____________________
[**SIGNATURE OF PATIENT (BENEFICIARY) AND/OR RESPONSIBLE PARTY**] [Date]

____ ____________________
[SIGNATURE OF NICA WITNESS] [Date]

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