

**ADVANCED BENEFICIARY NOTICE (ABN) AND
MEMBER (PATIENT) FINANCIAL RESPONSIBILITY AGREEMENT**

MEMBER (PATIENT) NAME: DANA MOOLANI **DOB:** 05111980

MEMBER ID NUMBER: 5094453290 **GROUP NUMBER:** NA

NOTICE TO MEMBER: Your health care benefit plan may prohibit participating health care professionals and/or facilities such as National Rehab Equipment, Inc. ("Providers") from charging members such as you for any service, product or upgrade that is deemed not medically necessary or non-covered for other reasons, unless the Member (such as you) specifically requests such service or product and agrees in writing to be financially responsible for it. This waiver form may be used to document your agreement to be financially responsible for such services and products. Your health care benefit plan may require that this document be executed prior to the delivery of any non-medically necessary or non-covered service or product.

ABN AND MEMBER FINANCIAL RESPONSIBILITY AGREEMENT: By signing below, I agree to pay Provider for those services and products determined for the reason(s) specified below not to be covered under my health care benefit plan:

- ☐ **Not medically necessary;**
- ☐ **Primarily for comfort or convenience;**
- ☐ **Upgraded products or extra accessories that exceed my plan's benefit**
- ☐ **Otherwise not a covered benefit or excluded under my coverage**

I understand that the Provider and/or I may appeal any determination that a service or product is not medically necessary or non-covered by filing a grievance or appeal pursuant to the grievance and appeals procedures described in my health care benefit plan or Evidence of Coverage.

I also understand that I am financially responsible for the difference between the covered expense ("Allowed Amount") for any covered services and products and the Total Cost listed below ("Member's (Patient's) Responsibility"), even though these amounts may not be shown on my Explanation of Benefits as my responsibility. If the Total Cost of the service and/or product is not covered under my health care benefit plan, I understand that I am financially responsible for the Total Cost. Or I may, in some situations, have the option to choose an upgraded version of a product. If the Provider's usual and customary charge for the upgraded product is higher than the reimbursement rate for the standard product as covered by my health care benefit plan, I understand and agree that I am financially responsible for the difference between my health care benefit plan's reimbursement rate for the standard model and the Provider's usual and customary charges for the deluxe or upgraded model. This difference, if any, is indicated in the "Member's (Patient's) Responsibility" column below.

| Date of Service | Amount of Service / Product / Upgrade | Member's (Patient's) Responsibility* |
|-----------------|---------------------------------------|--------------------------------------|
| 09232014 | \$95 | \$95 |
| | | |
| | | |

I acknowledge that National Rehab Equipment, Inc. has reviewed this Responsibility Agreement with me, and I have had an opportunity to ask questions. I also acknowledge that National Rehab Equipment, Inc. offered me the standard piece of equipment, which was the least costly alternative, and National Rehab Equipment, Inc. explained to me that my health care benefit plan would only pay, at the most, the allowed amount quoted above, subject to its usual eligibility requirements.

Member Signature  **Date** 9/23/14

*In addition to being financially responsible for this amount, I understand that I will be billed and held financially responsible for any applicable copayment, deductible and/or coinsurance as required by my health care benefit plan or Evidence of Coverage.

CREDIT CARD INFORMATION

NAME ON CREDIT CARD: Dana Moolani

PATIENT: Dana Moolani

PLEASE CHECK ONE: ☒ VISA ☐ MASTER CARD ☐ DISCOVER

CARD NUMBER: 4226 9500 0377 1207

EXP DATE: 11/16

3 DIGIT SEC. CODE: 743

ZIP CODE: 10019

UPGRADE ITEM: ☒ TOTE ☐ BACKPACK

OFFICIAL NEW YORK STATE PRESCRIPTION



JACQUES MORITZ MD
LIC: 188159
NPI: 1407857907

200 WEST 57TH STREET SUITE 1300 NEW YORK, NY 10019 (212) 603-4160

PRACTITIONER DEA NUMBER
BM3089441

Patient Name DANA MOOLAAI Date 9/12/2014

Address _____ City _____ State _____ Zip _____ Age _____ Sex M F

Rx DOB

MEDELA DOUBLE
ELECTRIC BREAST
PUMP (IN STYLE
ADVANCEST)

☐ LEP Preferred Language

29.3 Prescriber Signature X

THIS PRESCRIPTION WILL BE FILLED GENERALLY UNLESS PRESCRIBER WRITES 'day' IN THE BOX BELOW

REFILLS ☐ None ☐ Refills

MAXIMUM DAILY DOSE
(controlled substance only)
0RG5VH 33



PHARMACIST
TEST AREA:

Dispense As Written