**ADVANCED BENEFICIARY NOTICE**
**FOR OREGON HEALTH PLAN AND COMMERCIAL INSURANCE PATIENTS**

**I acknowledge that the following services will not be covered by the Oregon Health Plan or may not be covered by my commercial insurance and that I desire these services regardless.**

**I acknowledge that I am financially responsible for these charges not covered by Oregon Health Plan or my commercial insurance company.**

**Date of Service:_____**

| Procedure: DESCRIPTION | CODE | EST. COST | PT INT |
|---|---|---|---|
| Est patient visit(Follicular check) | 76830 | 280.00 | _____ |
| New patient visit (infertility) | 99204 | 420.00 | _____ |
| Est patient 1st visit (infertility) | 99215 | 375.00 | _____ |
| Est patient f/u visit (infertility) | 99213 | 193.00 | _____ |
| Artificial insemination (intra-uterine) | 58322 | 295.00 | _____ |
| Sperm Washing | 58323 | 200.00 | _____ |
| Hysteroscopy | 58555 | 788.00 | _____ |
| Injection | 90471 | 50.00 | _____ |
| Additional charge for weekend insemination | 99000 | 100.00 | _____ |

**Physician performing the service:_____**

**Patient name(print)_____**

**Responsible party(print)_____**

**Signed:_____**
**(Patient/Responsible Party)**

**Date signed:_____**

**Witnessed:_____**

**Rev 4/1/2022**