Date: [Insert Date]

Patient Name: [Insert Patient Name]
Patient ID: [Insert ID Number]

Subject: Voluntary Advance Beneficiary Notice (ABN)

Dear [Patient Name],

This letter is to inform you that the following service(s) or item(s) may not be covered by your insurance provider (Medicare or private insurance) for the reason(s) listed below:

Service/Item	Estimated Cost	Reason for Non-Coverage
[Insert Service]	$[0.00]	[e.g., Not medically necessary / Frequent limit reached]

Your Options:

- **Option 1:** You receive the services/items listed above and agree to be financially responsible for the full payment if insurance denies the claim.
- **Option 2:** You choose not to receive the services/items listed above.

By signing below, you acknowledge that you have been notified of potential non-coverage and agree to pay for the services if your insurance provider does not make payment.

Patient/Guardian Signature: _____
Date: _____

Provider Name: [Insert Provider/Facility Name]
Contact Information: [Insert Phone Number]