BEST START BIRTH CENTER

3630 Enterprise Street, San Diego, CA 92110 **Phone: 619-299-0840**

Advance Beneficiary Notice of Non-coverage (ABN) / Agreement for Non-Covered Services

Patient Name: _____ Health Insurance Plan: _____

DOB: _____ Insurance/Beneficiary #:_____

You are receiving this notice because your health plan **may not or does not pay** for all of the services that Best Start Birth Center ("Best Start," "we," or "our") believes will benefit you. Best Start has an established policy for billing all patients for services not covered by health plans. In compliance with our contracted health plans and government health program billing guidelines and requirements, **we are advising you of the specific non-covered services to be provided and the cost below**. Read this notice so you can make an informed decision about your care and our costs. Ask questions. Initial and date applicable services listed below:

For Medi-Cal Members: As a Medi-Cal member, you cannot be charged any additional fees or surcharges for accessing or receiving medically necessary freestanding birthing center services.

Initial & Date	Supplies and/or Services Initial & Date Each Selected Item	Reason insurance may not pay	Estimated Cost
	A) Kitchen for client/partner/support people. Includes other convenience/hospitality resources such as private room and bathroom/birth pool (No additional fee)	Non-Covered Services	All Inclusive Fee $500.00 Tricare reduced rate $250/ MCAL no fee
	B) Alternative labor comfort resources and services including: Hydrotherapy deep water immersion, Homeopathy, Nitrous Oxide, Rebozo, Birth Balls, Birth Stools, Sub-dermal Water Papules, TENs Unit, Essential oils, Acupressure, and other Complementary and Alternative services	Non-Covered Services	
Date and Initial: _____	C) Individual Prenatal, Birth and Postpartum Education and Mentoring for Birth Partner, Family, and Support Group	Non-Covered Services	Note: Bundled into inclusive charge, (A+B above) **No additional fee**
Date and Initial: _____	D) Personal Disposable Nitrous Oxide Inhaler (Mouthpiece/Mask)	Non-Covered Service	$50 No additional cost for Medi-Cal
Date and Initial: _____	E) Childbirth Preparation Series for Client/Birth Partner/Support Person	Non-Covered Service	$275.00 No additional cost for Medi-Cal and Tricare/Active Military Beneficiaries
Date and Initial: _____	F) Early Post-partum Follow-up in Home	Non-Covered Service	$200.00 (No Fee if visit is done at Birth Center)
Date and Initial: _____	G) Non-clinical Paperwork/Electronic Submissions (disability, return to work, FMLA, birth certificate, SS card, etc.)	Non-Covered Services	$30.00 (No charge Medi-Cal/Tricare)

☐ **YES**, I want to receive these services. I am the patient or responsible party, am legally authorized to sign below, and understand that my health plan does not or may not pay for the services described above. I have been told what the expected cost will be and why I may be billed. I have been informed and have signed this agreement before receiving the described services. I accept complete financial responsibility for and agree to pay Best Start's charges as described above.

☐ **NO**, I do not wish to receive these services.

☐**OTHER**, Should I decide to request these services in the future, I understand I will be charged and am responsible for payment in full of the services I choose.

By signing this agreement, I accept financial responsibility for the cost of the non-covered supplies and services listed above.

_____ _____/_____/_____

Patient / Responsible Party Signature **Date**

By signing below, Provider agrees not to bill health plan for any services covered by this ABN/Agreement for Non-Covered Services:

_____ _____/_____/_____

Provider Representative Signature **Date**