Advanced Beneficiary Notice (ABN)
Insurance 2016

Questions about how to complete this form?

Call: **713-520-1210**
(8 am to 5pm CST)

www.rocmd.com

Return completed form to:

Reconstructive Orthopedic Center of Houston
1213 Hermann Dr. - Suite 380
Houston, TX 77004

Or fax form to:
713-527-8898

Buddy Tapes	99070T06	10.18 ea
50/50 elastomer	A6206015	10.63oz
Cica Care	(A6025035)	7.56 in
CMC/MP gel sleeve	(A6025CMC)	34.50 ea
Coban roll 1"	(A6453015)	6.06 ea
Coban roll 2"	(A6453025)	10.35 ea
Coban roll 3"	(A6453035)	12.75 ea
CT relief sleeve s/m	(A6025 CTR)	85.47
CT relief sleeve l/xl	(A6025CTRLXL)	91.47
Cylindrical Foam	(A4636015)	.63 in
DigiCap silicon s-m	(A6025025SM)	10.86
DigiCap siliconLXL	A60250255L	14.95
DigiCap silicon XXL	A60250255XXL	15.5
Digi Sleeve	(A6448035)	4.79 in
Digi Sleeve silontex	(A6025015)	8.17 in
Dispersal electrode	(A4556035)	44.85
Electrodes 2"	(A4556015)	30.75
Electrodes 1.25"	(A4556025)	27.75
Cervical Traction	(E0860015)	65.25
Flexion glove	S24601 L3912	107.58
Foam Blocks	(A9300045)	13.24
Glove Edema (open)	(A6449025)	29.85
Glove Isotoner (op/cl)	(A6449035)	36.30

Hot/Cold Pack	(E0238015)	12.60
Hand Helper	(A9300055)	50.10
Joint Gel Sleeve	(A6025SLV)	65.70
Mini Massager	(A9900015)	53.10
Mint elbow sleeve	A6025mint	56.85
MS3 Pack II	(A9300-SH)	75.00
Nu Gel	(A6025036)	5.18 in
Overhead Pulleys	(A9300175)	53.85
Posture Corrector	S202112 L3675	148.78
Power hand gripper	(A9300065)	94.80
Theraputty 4oz	(A9300125)	17.25
Theratube yellow	(A9300135)	2.66 yd
Theratube red	(A9300145)	3.03 yd
Theratube green	(A9300155)	3.33 yd
Theratube blue	(A9300165)	3.70 yd
Theraband yellow	(A9300085)	5.17 yd
Theraband red	(A9300095)	5.49 yd
Theraband green	(A9300105)	5.93 yd
Theraband blue	(A9300115)	6.61 yd
Theraband black	(A9300106)	10.60 yd

Tubigrip B	(A6449045)	.66 in
Tubigrip C	(A6449055)	.76 in
Tubigrip D	(A6449065)	.86 in
Tubigrip E	(A6449075)	.93 in
White Digi caps sm	A6025WhiteSM	12.32
White Digi caps lxl	A6025Whitelx	18.18
2.5" Small Gel Disk	A6025smDisk	25.73
4" Large Gel Disk	A6025lgDisk	31.80
Post op shoe	L3260	23.92
Short Walking Boot	S3102-L4360	499.00
Long Walking Boot	S3103-L4360	499.00
Lycra Cotton Sleeve	S4113-L2850	173.10
Neoprene Sleeve	S4114 L 2397	304.53

3PP Thumsling NP	S2570 L3923	221.16
3PP Thumspica	S2571 L3908	152.34
PICCI inflatible spl	S22715 L3807	218.99
Push Metagrip	S257615 L3932	202.58
Add:		
Add:		

CPT Codes

97001 PT Eval	$229.14
97002 PT Re-eval	$128.07
97003 OT Eval	$259.29
97004 OT Re-eval	$160.44

Modalities Supervised

G0283 Electrical Stim.Unattended	$42.27
97012 Mechanical Traction	$48.84
97022 Whirlpool	$71.40

Functional Procedures

97535 Self-care train. ea.15 min	$106.32
97750 FCE (ea.15 min)	$100.86

Modalities Constant Attendance

97032 E Stim Man 15 mins	58.56
97033 Iontophoresis 15 min.	99.57
97035 Ultrasound	39.09
97022T Fluidotherapy	71.40
64550 TENS HEP instruction	48.75

Woundcare

97597 Debridement	<20 cm	232.50
97598 Debridement	> 20 cm	76.8
97750T Phys.Perform Test (15 min)		$100.32

Splinting/Custom (HCPCS)

97760 Ortho train/fit ea. 15 min	115.98

Therapeutic Procedure

97110 Therapeutic Proc ea15 min	98.70
97112 Neuromusc Re-Ed. 15 min	102.00
97530 Therapeutic Act. Dir15min	106.32
97140 Manual Therapy (MFR/Jt Mob)	91.20
29240 Strapping Shoulder	88.92
90901 Biofeedback per 15 min	115.92

Please choose ONE option. Check ONE box then SIGN and DATE your choice.

OPTION 1. Yes ___ I want to receive these items or services.

I understand that my insurance will not decide whether to pay or unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my insurance's decision.

OPTION 2. No ___ I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that insurance won't pay.

Print Name:	Signature:
Patient's DOB:	Date: