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Advance Beneficiary Notice of Noncoverage (ABN)

Patient Name: _____ Date: _____

In accordance with CMS guidelines, these services may not be covered if they do not meet the established criteria. Therefore, we kindly request that you sign this notice.

Services may not pay for these tests if they are deemed not medically necessary or if they do not meet CMS coverage criteria below.

- **Lipid Profile (80061):**

- Blood test used to measure cholesterol levels and assess cardiovascular risk.
- Estimated cost: \$14.00
- **Coverage Criteria:**
 - **One** claim will be processed every 12 months unless medical necessity is documented necessary
 - **Screening:** Coverage is provided once every 60 months (5 years).
 - **Annual Testing:** Permitted for patients on long-term antihyperlipidemic therapy and those with borderline high cholesterol levels.
 - **Component Testing:** Serum total cholesterol or LDL may be measured during interim visits if hypertriglyceridemia is not present. Up to six tests can be performed in the first year to monitor therapy.

- **Vitamin D (82306)**

- A blood test to determine the levels of vitamin D in your body.
- Estimated cost: \$31.00
- **Coverage Criteria:**
 - **One** claim will be processed every 12 months unless medical necessity is documented necessary
 - **Screening:** Not Covered
 - **Annual Testing:** May be appropriate based on specific medical necessity
 - **Follow up Testing:** If target levels are not achieved, retesting can be conducted every three months with a signed Advance Beneficiary Notice (ABN).

Acknowledgment: I understand that my insurance may not cover the services mentioned above, and if I decide to proceed with them, I agree to pay for any related expenses.

Patient Signature: _____ Date: _____