Patient name:
Identification number: *(optional)*

*Notifier name*
*Notifier address*
*Notifier phone (including TTY)*

~~A. Notifier:~~

~~B. Patient Name: C. Identification Number:~~

## Advance Beneficiary Notice of Non-coverage (ABN)

~~NOTE: If Medicare doesn't pay for D. below, you may have to pay.~~

Medicare does n'ot pay for everything, even some care ~~that~~ you or your health care provider ~~have good reason to~~ think you need. **We expect Medicare may not pay for the ~~D.~~ item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

| ~~D.~~Item, test, service or care | ~~E.~~ Reason Medicare m~~M~~ay n~~N~~ot p~~P~~ay~~:~~ | ~~F.~~ Estimated c~~C~~ost |
|---|---|---|
| | | |

**~~WHAT YOU NEED TO DO NOW:~~What to do now**

- Read this notice ~~, so you can~~to make an informed decision about your care.
- Ask ~~us~~ any questions ~~that~~ you have ~~after you finish reading~~.
- Choose one option below to let us know if you still want to ~~receive the D.~~ get the item, test, service or care.~~**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.~~
-

~~G. OPTIONS: Check only one box~~**Choose ONE option below. We can'~~n~~ot choose ~~a box~~ for you.**

If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

○ **Option 1: ~~OPTION 1.~~ I want the item, test, service or care ~~D.~~ listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN).** ~~—~~ You ~~may~~ can ask to be paid now~~.~~ ~~, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN).~~ I understand that if Medicare doesn't pay, I'~~a~~m responsible ~~for~~ to pay~~ment~~, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'~~w~~ill refund any payments I made to you, ~~less~~ minus co-pays or deductibles.

☐ **Option 2:**

○ **~~OPTION 2.~~ I want the item, test, service or care listed above~~D. listed above~~, but do n'~~o~~t bill Medicare.** You ~~may~~ can ask to be paid now ~~as~~ and I'~~a~~m responsible ~~for~~ to pay~~ment~~. I understand that I can'~~no~~t appeal, since ~~if~~ Medicare is n'~~o~~t billed.

☐ **Option 3:**



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○ ~~OPTION 3.~~ **I don't want the item, test, service or care ~~D.~~ listed above.** I understand ~~with this choice~~ I~~'~~ ~~am~~ not responsible for payment~~,~~ and I can~~'not~~ appeal to see if Medicare would pay.

~~H.~~

~~I.~~ **Additional information:~~:~~

This notice gives our opinion, not an official Medicare decision. For other questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). ~~/~~TTY users can call ~~:~~ 1-877-486-2048. Signing below means ~~that~~ you ~~have~~ received and understand this notice. You ~~may~~ can ask to ~~receive~~ get a copy.

| ~~I.~~ **Signature~~:~~ | ~~J.~~ **Date** (mm/dd/yyyy)~~:~~ |
|---|---|

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. This information collection is for providers, suppliers, Hospice and Religious Non-medical HealthCare Institutes and Home Health Agencies to notify original Medicare beneficiaries of their potential financial liability under specific conditions. The time required to complete this information collection is estimated to average less than X minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1879 of the Social Security Act, 42 CFR 411.404(b) and (c) and 411.408(d)(2) and (f). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

~~**Paperwork Reduction Act:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.~~



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