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Pinellas Hematology and Oncology
COMPASSIONATE CANCER CARE

A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

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

Medicare does not 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.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  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. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may 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 am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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COMMERCIAL INSURANCE ADVANCE BENEFICIARY NOTICE

PATIENT'S NAME_____

INSURANCE COMPANY_____(Plan)

We expect that the above named insurance plan will not pay for the products/ supplies that are described below. The plan does not pay for all of your health care cost. The plan only pays for covered items and services when the plan's rules are met. The fact that the plan may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor has recommended it.
Items/supplies to be received:

Your insurance may or may not cover these items indicated below for the following reasons:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these supplies, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.
Ask us to explain if you don't understand why the plan probably won't pay. Your cost for these items or supplies will be: $_____in case you have to pay for them yourself or through other insurance plans.

Please circle yes or no below to signify your choice

Please sign and date this form below to attest your choice

- YES I want to receive these tests/supplies

I understand that my plan will not decide whether to pay unless I receive these tests/supplies. Please submit my claim to my plan. I understand that you may bill me for tests/supplies and that I may have to pay the bill while my plan is making its decision. If my plan 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 that I can appeal my plans decision.

- NO I have decided not to receive these tests/supplies

I will not receive these items/supplies. I understand that you will not be able to submit a claim to my plan and that I will not be able to appeal your opinion that my plan won't pay. I will notify any referral doctor who ordered these tests/supplies that I did not receive them.

_____ _____

Signature patient or person acting on Patient's behalf Date