

**Advance Beneficiary Notice of Noncoverage (ABN)**

Patient Name \_\_\_\_\_ Identification Number \_\_\_\_\_

**NOTE:** If your insurance carrier does not cover the item(s) listed below, you may have to pay. Insurance carriers do not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance carrier may not pay for the item(s) listed below.

Item(s) Not Covered	Reason Medicare May Not Pay	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 item(s) listed above.

If you choose **Option 1 or 2**, we may help you to use any other insurance that you might have, but insurance carriers cannot require us to do this.

<b>OPTIONS: Check only one box. We cannot choose a box for you.</b>
<input type="checkbox"/> <b>OPTION 1.</b> I want the item(s) listed above, but I also want my insurance carrier billed for an official decision on payment. I understand that if my insurance carrier does not pay, I am responsible for payment. If my insurance carrier does pay, you will refund any payments I made to you, less co-payments or deductibles.
<input type="checkbox"/> <b>OPTION 2.</b> I want the item(s) listed above, but do not bill my insurance carrier as I am responsible for payment. <b>I cannot appeal if my insurance carrier is not billed.</b>
<input type="checkbox"/> <b>OPTION 3.</b> I do not want the item(s) listed above. I understand with this choice I am <b>not</b> responsible for payment.

**Additional Information:**

This notice gives our opinion, not an official CMS or private insurance carrier decision. If you have other questions on this notice or insurance billing, please call your insurance carrier. **Signing below means that you have received and understand this notice.**

<b>Signature:</b>	<b>Date:</b>
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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.