

(A) Supplier/Provider: \_\_\_\_\_

(B) Beneficiary Name: \_\_\_\_\_ (C) Identification Number: \_\_\_\_\_

## Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE: If Medicare does not pay for things listed below, you may have to pay.**

We think Medicare will not pay for the “**Item(s)/Service(s)**” listed below because of certain rules for coverage described under “**Reason**”. You still can receive this care, since you or your health care provider may have good reason to think you need it, but it is likely you or other insurance will have to pay. We have estimated about how much you may have to pay under “**Estimated Cost**” to help you decide whether or not to receive the care listed.

(D) Item(s)/Service(s):	(E) Reason:	(F) Estimated Cost:

- **Medicare wants us to be sure you make an informed choice.** Read this whole notice, which explains our opinion that Medicare won’t pay. **This is not an official Medicare decision.** Ask us for more explanation if you need it. For questions on this notice or on Medicare billing, you can also call **1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048)**.
- **You need to make a choice about receiving the care listed above.** You must choose **only one** of the three options below. **We cannot choose for you.**
- **We must bill Medicare when you ask us to.** We may help you with billing other insurance if you choose Option 2 or 3 below, though Medicare cannot require us to do this.

### (G) OPTIONS

- 1. Do not provide me with anything listed above.** With no care provided, there is no billing. I understand that **I cannot appeal** to Medicare when choosing this option.
- 2. Provide me with what is listed above. I do not want Medicare billed. I agree to be responsible for payment.** I understand that **I cannot appeal** to Medicare when choosing this option.
- 3. Provide me with what is listed above. I want you to bill Medicare for an official decision on payment. You can ask for payment now that will be refunded if Medicare pays.** I understand that if Medicare does not pay, **I can appeal that decision.**

(H) Other insurance to consider for billing: \_\_\_\_\_

Your signature below means that you have received this notice and understand it. You will also get a copy.

(I) Signature: \_\_\_\_\_

(J) Date: \_\_\_\_\_

**PRIVACY NOTICE:** 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 (0 hours)(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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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