Patient Name: Medicare ID#:

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving this health care service.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. Right now, in your case, **Medicare will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will 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 Medicare does not pay for this service.
- Ask us how much these items or services will cost you today (**Estimated Cost: $**_____),

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐**Option 1. YES. I want to receive these items or services.** I understand that Medicare will not cover the cost of today's service. I agree to be personally and fully responsible for payment. That is, I will pay out of pocket for today's charges that are not billable to Medicare.

☐**Option 2. NO. I have decided not to receive these items or services.** I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date **Signature of Patient or Person acting on patients behalf.**