ADVANCED BENEFICIARY NOTICE (ABN)

(Please provide information in box)

Date: _____ Patient name: _____ Insurance/Medicare #:_____

We expect that your insurance/Medicare may not pay for the item(s) that are described below. 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 might have to pay for them yourself. **Before you make a decision about your options, you should read this entire notice carefully.**

Your insurance/Medicare does not pay for **all** of your health care costs. Your insurance/Medicare only pays for covered items and services when insurance/Medicare rules are met. The fact that your insurance/Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason you doctor recommended it.

Right now, in your case, your insurance/Medicare probably will not pay for

- ☐ Electrocardiogram, complete (93000)
- ☐ Tetanus and diphtheria toxoids vaccine (Td-90714)
- ☐ Tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap-90715)
- ☐ Physical Exam
- ☐ Laboratory Services (Any applicable charges will be received from the laboratory directly.)
- ☐ Other _____

This is because

- ☐ Many insurances plans, including Medicare, do not cover these services.
- ☐ Other _____

Ask Medics USA to explain, if you don't understand why your insurance/Medicare probably won't pay.
Ask us how much these items or services will cost you, in case you have to pay for them yourself or through another insurance. Estimated Cost $_____

(Please provide information in box)

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 my insurance/Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance/Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance/Medicare is making its decision. If my insurance/Medicare does pay, you will refund to me any payments I made to you that are due to me. If my insurance/Medicare 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 insurance/Medicare's decision.

☐ 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 my insurance/Medicare and that I will not be able to appeal your opinion that my insurance/Medicare won't pay.

By signing below I acknowledge that I have read and understood all the information above.

_____ _____

Date Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your information which Medicare sees will be kept confidential by Medicare.