

Notifier(s):

Patient Name:

Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for laboratory test(s) 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 laboratory test(s) below.

Laboratory Test(s)	Reason Medicare May Not Pay:	Estimated Cost:
<input type="checkbox"/> Thin Prep Pap, Screening <input type="checkbox"/> Occult Blood, Screening <input type="checkbox"/> PSA, Screening <input type="checkbox"/> Other _____ _____ _____ _____	<input type="checkbox"/> Medicare does not pay for these tests as often as this (denied as too frequent) <input type="checkbox"/> Medicare does not pay for these tests for your condition <input type="checkbox"/> Medicare does not pay for experimental or research tests <input type="checkbox"/> Other _____ _____	

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 laboratory test(s) listed above.

Note: Although not required by the Medicare program, if you choose Option 1 or 2, we will help you file any other insurance you have.

OPTIONS: Check only one box. We cannot choose a box for you.
<input type="checkbox"/> OPTION 1. I want the laboratory test(s) 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.
<input type="checkbox"/> OPTION 2. I want the laboratory test(s) 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.
<input type="checkbox"/> OPTION 3. I don't want the laboratory test(s) listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information: If option 3 was selected, you should notify your doctor who orders these laboratory test you did not receive them.

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.

Signature:	Date:
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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.

Instructions for Completing ABN

1. Enter name of Notifier ie: Dr. Smith or South Bend Medical Foundation
2. Enter Patient's Legal Name
Do not substitute name of authorized representative if patient is unable to sign.
3. Enter Patient's Accession Number (Optional).
4. Enter the name of the test you believe Medicare will not cover or check the appropriate preprinted test name in the box.
5. Enter the reason Medicare may not pay or check the appropriate preprinted reason in the box.
6. Enter the Estimated cost of the test(s) you believe Medicare will not cover.

Reminder: Some tests may have multiple charges, depending on the extent of testing performed. See Medical Necessity Guide Book or Patient Fee Schedule for test(s)cost.

7. The Patient must personally select an option to either receive the service and bill Medicare, receive the service and not bill Medicare, OR not to receive the service. Marking the box for pre-selection is prohibited.
8. Have the Patient enter the date on which he or she signed the ABN. Have the Patient sign their name. If the Patient is unable to select an option and sign and date the ABN, an authorized representative may do so on their behalf.
9. The Patient must receive a copy of the completed ABN.

National and Local Coverage Determinations Test List

Acid Phosphatase, Prostatic	Hepatitis, Viral Serology Testing
Acid Phosphatase, Total	Hepatitis Panel
Allergen (Rast Type Test)	High Sensitivity C-Reactive Protein (hs-CRP)
Alpha Feto Protein, Serum	HIV, Diagnostic
Brain-Type Natriuretic Peptide (BNP)	HIV, Monitoring
CA 125	Homocysteine Syphilis Testing
CA 15-3/27.29	Iron Studies
CA 19-9	Lipid Testing
CBC (Complete Blood Count)	Occult Blood, Screen
CEA	Occult Blood, Diagnostic
Collagen Cross Links	PSA, Diagnostic
Digoxin	PSA, Screen
ESR (Erythrocyte Sedimentation Rate)	PT (Prothrombin Time)
GGTP	PTT (Partial Thromboplastin Time)
Glucose, Blood	Syphilis Testing
HCG, Quantitative	Thin Prep Pap Test, Screen
Hemoglobin A1C	Thyroid Testing
	Urine Culture, Quantitative

Refer to the South Bend Medical Foundation Medical Necessity Guidebook for a complete list of tests and the estimated cost of each test.



530 N. Lafayette Blvd. • South Bend, IN 46601
 (574) 234-4176 • (800) 544-0925
 www.sbmf.org

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Hemoglobin A1C	Thyroid Testing
	Urine Culture, Quantitative

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