



ADVANCE BENEFICIARY NOTICE FOR MEDICARE PATIENTS

Last name

First name

DOB

Address

SSN

Secondary insurance information, if any (list name, policy #, group #, plan, insured's name)

Tertiary insurance information, if any (list name, policy #, group #, plan, insured's name)

PATIENT NOTICE

If Medicare or any supplemental insurance I may have does not pay for the care and services I receive, I may have to pay. I understand that Medicare and any other insurance I may have does not pay for everything. Even some care/services that I or my health care provider have reason to think I need, may not be paid for by my insurance.

The following care and services may not be covered by insurance. Other care and services that you may receive not listed below may not be covered.

Disclaimer: While the information and guidance provided in this document is believed to be current and accurate at the time of posting, it is not intended to be and should not be construed to be or relied upon as legal, financial, or consulting advice. Before use, each document should be tailored to the unique nature of your practice, including applicable state law. Consult with an attorney and other advisors. References and links to third parties do not constitute an endorsement or sponsorship by the AMA, and the AMA hereby disclaims all express and implied warranties of any kind in the information provided.

Evaluation & management: _____

Diagnostics: _____

Procedures: _____

Other: _____

Services that Medicare or other insurance may not pay for and possible reasons for non-payment: [Office staff use only]

Services are not covered by the insurance

Services are deemed not medically necessary

Services are considered experimental

Service frequency exceeds cap

Provider is not authorized Other:

INFORMATION FROM YOUR PHYSICIAN

Read this notice so you can make an informed decision about your care. After you finish reading, ask us any questions you may have. Choose an option below about whether to receive the services listed above.

OPTIONS: (Check only one box)

OPTION 1. I want the services listed above and I want Medicare and any supplemental insurance to be billed. I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to Medicare or my supplemental insurance carrier(s). If my insurance carrier does pay, I will be refunded any payments I made to my provider, less co-pays and deductibles.

OPTION 2. I want the services listed above, but do not bill my insurance. I will be asked to pay for the services now. I cannot appeal if my insurance is not billed.

OPTION 3. I do not want the services listed above. I understand that with this choice I am not responsible for payment and I cannot appeal to see if my insurance would pay. I may also be asked to sign an informed refusal document by my health care provider.

ADDITIONAL INFORMATION

This notice is an opinion, not an official coverage decision. If you have coverage questions, call your insurance carrier on the number given on the back of the card. Signing below means that you agree to adhere to the terms of this notice.

Patient signature

Print name

Date

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