



Patient Name: _____

Medicare # (HICN) _____

Advance Beneficiary Notice

Note: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) that are described below.

Medicare does not pay for all 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. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for.

Screening Mammography

This exam is covered only once every twelve - (12) months.

Chest X-ray

Routine & screening exams are not covered, including pre-operative x-rays, unless there is a diagnostic need.

Low Osmolar contrast material or Non-Ionic contrast material.

Low Osmolar contrast material may be used with the presence of specified medical conditions. If these conditions are not present, then Medicare may deny LOCM charges.

Carotid Doppler/Carotid Duplex

This service is not covered for a diagnosis of dizziness.

Bone Density Analysis

Medicare covers a bone mass measurement once every 2 years and only more frequently if the individual has documented deficiency or is on osteoporosis drug therapy.

Magnetic Resonance Angiography/MRA

The diagnosis of _____ is not listed in the Indications of Coverage and will be denied as not reasonable & necessary under Section 1862(a)(1)(A).

Magnetic Resonance Imaging/MRI Head (Brain)

The diagnosis of _____ is not listed in the Indications of Coverage and will be denied as not reasonable & necessary under Section 1862(a)(1)(A).

Magnetic Resonance Imaging/Breast

This service is not considered a medical necessity by Medicare. An appeal will have to be filed to prove medical necessity.

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.

**Ask us to explain if you don't understand why Medicare probably won't pay.

**Ask us how much these items or services will cost you (Estimate Cost: \$ _____), in case you have to pay for them yourself or through other insurance.

YES I want to receive these items or services

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If 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 I can appeal Medicare's decision.

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 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 health information which Medicare sees will be kept confidential by Medicare.