Notifier(s):

Patient Name: **Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) (MEDICARE)

NOTE: If Medicare doesn't pay for items checked or listed in the box 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 items listed or checked in the box below.

Listed or Checked Items Only:	Alpha-fetoprotein, Serum Amylase BRCA 1&2 CA 15-3/CA 27.29 CA 125 CA 19.9 CBC CEA Cholesterol Collagen Cross Link Cytogenic Studies Digoxin Fecal Occult Blood Ferritin Fructosamine (Glycated Protein) Genetic Testing GGT (Gamma Glutamyl Tranferase) Glucose, Serum or Plasma Lipoprotein A2 & Apolipoprotein	Lipoprotein Glycated Hemoglobin A/C FSH LH Gonadotropin HCG, Serum Quant. HDL, Cholesterol Hematocrit Hemoglobin Hepatic Function Panel, AMA Hepatitis Panel (Acute), AMA Hepatitis C, RNA HIV 1 Ab/Reflex Westerm Blot HIV 1 RNA Iron Binding Capacity LDL Cholesterol, Direct Lipid Panel Lipoprotein Electrophoresis Magnesium Partial Thromboplastin Time (PTT) Vaginosis Panel, GI BIOFIRE, ZIKA, all Genetic Testing	Platelet Count Prothombin Time (PT) with INR PSA Total PSA Free RPR/VDRL Sedimentation Rate T3 Uptake T4, Free T4, Total Transferrin Triglycerides Troponin TSH Urine Culture/Reflex Sensitivity **Medicare Screens:** Fecal Occult Blood Pap Smear Liquid Based PapTest PSA Total
Reason Medicare May Not Pay:			
Estimated Cost:			

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 checked items listed in the first box above. **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the ____ 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.

☐ **OPTION 2.** I want the _____ 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**.

☐ **OPTION 3.** I don't want the _____ 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:

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:**

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.

Form CMS-R-131 (03/08)

Form Approved OMB No. 0938-0566

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) (INSURANCE)

NOTE: If your insurance doesn't pay for items checked or listed in the box below, you may have to pay. Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:	SEE ABOVE CHART FOR TEST ITEMS		
Reason Medicare May Not Pay:			
Estimated Cost:			

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 checked items listed in the first box above. **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the _____ listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on an Explanation Benefits(EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance** by following the directions on the EOB. If my insurance pay, you will refund any payments I made,less co-pays or deductibles.

☐ **OPTION 2.** I want the _____ listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed**

☐ **OPTION 3.** I don't want the _____ listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if my insurance would pay.

Additional Information:

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice or insurance billing, call the member services number on your insurance card. Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**