

Patient's Name:

Medicare # (HICN):

# ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these laboratory tests.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of 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 the laboratory test(s) indicated below for the following reasons:**

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as too frequent)	Medicare does not pay for experimental or research use tests

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, 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 laboratory tests will cost you (**Estimated Cost: \$**\_\_\_\_\_), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

**Option 1. YES. I want to receive these laboratory tests.**

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

**Option 2. NO. I have decided not to receive these laboratory tests.**

I will not receive these laboratory tests. 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. I will notify my doctor who ordered these laboratory tests that I did not receive them.

\_\_\_\_\_ **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.