

**McLaren Print System Order**

**Order No: 17683 Reprint Previous Order No: 5396**  
**Order Date: 2016-03-15**  
**User: Michele Lubick**  
**Phone: 586-263-0320**

**Ship Location: McLaren Macomb Family Medicine-Michele**  
**16700 21 Mile Rd., Suite 101**  
**Macomb, MI 48044**

**Forms**  
**Quantity: 500**  
**Paragon Dept No: 71600**  
**Dept Name: McLaren Macomb Family Medicine**  
**Company Number: 810**

**Order Total Price: 94.75**

**Item Number: MM-103A (8931) English**  
**Item Description: ABN (McLaren Macomb Family Medicine Suite 101)**  
**Revision Date: 1/2012**  
**Print: 1 sided black and white**  
**Paper: 3 Part (White, Yellow, Pink)**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: None**  
**Misc Info:**

McLAREN MACOMB FAMILY MEDICINE  
16700 21 Mile Road • Suite 101 • Macomb, MI 48044  
(586) 263-6120 • Fax (586) 263-1276

|   |                              |
|---|------------------------------|
| <small>Provider(s)</small>                              | <small>Patient Name:</small> |
| <b>ADVANCED BENEFICIARY NOTICE OF NONCOVERAGE (ABN)</b> |                              |

NOTE: If Medicare doesn't pay for D \_\_\_\_\_ before, you may have to pay. Medicare does not pay for everything, even some cases that you or your health care provider have good reasons to think you need. We expect Medicare may not pay for the D \_\_\_\_\_ before.

| <small>Checked<br/>Date<br/>(Only)</small> | <small>Item or Service</small>                          | <small>Reason Medicare May Not Pay</small>                               | <small>Estimated<br/>Cost</small> |
|--|---|--|-----------------------------------|
| <input checked="" type="checkbox"/>        | <small>In-Office Signature &amp; Administration</small> | <small>Medicare doesn't pay for this service for your condition.</small> | <small>\$17.00</small>            |
| <input checked="" type="checkbox"/>        | <small>Chart Work</small>                               | <small>Medicare doesn't pay for this service for your condition.</small> | <small>\$47.00</small>            |
| <input checked="" type="checkbox"/>        | <small>GI/X-ray/complex</small>                         | <small>Medicare doesn't pay for this service for your condition.</small> | <small>\$41.00</small>            |
| <input checked="" type="checkbox"/>        | <small>Hemework</small>                                 | <small>Medicare doesn't pay for this service for your condition.</small> | <small>\$1.00</small>             |
| <input checked="" type="checkbox"/>        | <small>Ultrasono</small>                                | <small>Medicare doesn't pay for this service for your condition.</small> | <small>\$11.00</small>            |
| <input checked="" type="checkbox"/>        | <small>PAF Exam</small>                                 | <small>Medicare doesn't pay for this service as often as this.</small>   | <small>\$79.00</small>            |
| <input checked="" type="checkbox"/>        | <small>QTN Exam</small>                                 | <small>Medicare doesn't pay for this service as often as this.</small>   | <small>\$119.00</small>           |
|  |   |  |                                   |
|  |   |  |                                   |
|  |   |  |                                   |

Who is your doctor or provider?  
 \*Read this notice, so you can make an informed decision about your care.  
 \*Ask us only questions that you may have after you finish reading.  
 \*Check an option below about whether to receive the D \_\_\_\_\_ listed above.  
**NOTE:** If you choose option 1 or 2, we may help you receive any extra assistance 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 some, but I also want Medicare to be billed for an official decision on payment, which is sent to the area Medicare beneficiary hotline (MBH). I understand that if Medicare doesn't pay, I am responsible for payment, but I am appealing to Medicare by following the directions on the MBH. If Medicare does pay, you will refund any payments I made to you, less charges or deductions.

**OPTION 2:** I want the \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid some, but 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).

Sign your name that you have received and understood this notice. You also receive a copy.

|                         |                    |
|-------------------------|--------------------|
| <b>Signature:</b> _____ | <b>Date:</b> _____ |
|-------------------------|--------------------|

Medicare is the national program that provides health insurance to eligible people. It includes parts A (hospital & medical) and B (doctor services). The cost of Medicare is based on the amount of earnings you made while you worked. You must be at least 65 years old to be eligible for Medicare, unless you have a disability. Medicare is a federal program that is managed by the Social Security Administration. Medicare does not cover long-term care. For more information, see Medicare.gov.

Form MM-103A (8931) 1/2012 WHITE RECORD YELLOW PATIENT PINK ROUTER For approved 018 to 3/31/09