

## McLaren Print System Order

Order No: 45521 Reprint Previous Order No: 28183  
 Order Date: 2019-05-22  
 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: 100  
 Paragon Dept No: 71600  
 Dept Name: McLaren Macomb Family Medicine  
 Company Number: 810

Order Total Price: 56.45

Item Number: MM-103A  
 Item Description: ABN English  
 Revision Date: 3/2017  
 Print: 1 sided black and white  
 Paper: 3 Part (White, Yellow, Pink)  
 Size: 8.5 x 11  
 Fold:  
 Finish: None  
 Drill: None  
 Misc Info: 3 part; ss; black and white

A. Notifier: \_\_\_\_\_ C. Identification Number: \_\_\_\_\_  
 B. Patient Name: \_\_\_\_\_

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**Advance Beneficiary Notice of Noncoverage (ABN)**

**NOTE:** If Medicare doesn't pay for D. \_\_\_\_\_ 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 D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. 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 D. \_\_\_\_\_ listed 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.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

**OPTION 1.** I want the D. \_\_\_\_\_ 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 D. \_\_\_\_\_ 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 D. \_\_\_\_\_ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. 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.

I. Signature: \_\_\_\_\_ J. Date: \_\_\_\_\_

CMH does not discriminate in its program and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cmh.edu](mailto:AltFormatRequest@cmh.edu).

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Form CMH-06-031 (5/19-03/2020) Form Approved OMB No. 0938-0166

WHITE: RECORD YELLOW: PATIENT PINK: ROUTER