

McLaren Print System Order

Order No: 46024 Reprint Previous Order No: 28183
 Order Date: 2019-06-05
 User: Kimberly Smirnes
 Phone: 586-466-4810

Ship Location: McLaren Macomb Heart Rhythm Treatment Center
 21550 Harrington Blvd., Suite C
 Clinton Township, MI 48036

Forms

Quantity: 100
 Paragon Dept No: 72400
 Dept Name: McLaren Macomb Heart Rhythm Treatment Center
 Company Number: 810

Order Total Price: 33.41

Item Number: MM-103A
 Item Description: ABN English
 Revision Date: 3/2017
 Print: 2 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: _____

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: _____

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Form CMS-86-031 (04/96-03/2020) Form Approved OMB No. 0938-0186

WHITE: RECORD YELLOW: PATIENT PINK: ROUTER