

**McLAREN NORTHERN
CHEBOYGAN, COMMUNITY MEDICAL CENTER
740 S. Main • SUITE 2C • Cheboygan, MI 49721
231-627-3002**

Notifier(s): _____

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.

Checked Items Only:	Items or Services:	Reason Medicare May Not Pay:	Estimated Cost:
<input type="checkbox"/>	B-12 Injection & Administration	Medicare does not pay for this service for your condition	\$37.00
<input type="checkbox"/>	Chest X-ray	Medicare does not pay for this service for your condition	\$87.00
<input type="checkbox"/>	EKG, complete	Medicare does not pay for this service for your condition	\$61.00
<input type="checkbox"/>	Hemocult	Medicare does not pay for this service for your condition	\$16.00
<input type="checkbox"/>	Urinalysis	Medicare does not pay for this service for your condition	\$15.00
<input type="checkbox"/>	PAP Smear	Medicare does not pay for this service as often as this	\$70.00
<input type="checkbox"/>	GYN Exam	Medicare does not pay for this service as often as this	\$119.00
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			

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.

Options: Check only one box. We cannot choose a box for you.
<input type="checkbox"/> 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.
<input type="checkbox"/> 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.
<input type="checkbox"/> 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: _____
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