

McLaren Print System Order

Order No: 69172 Reprint Previous Order No: 28183
 Order Date: 2022-04-20
 User: Michelle Poindexter
 Phone: 810-714-9660

Ship Location: McLaren Fenton Family Medicine Michelle
 17200 Silver Parkway Suite 1
 Fenton, MI 48430

Forms

Quantity: 100
 Paragon Dept No: 50022
 Dept Name: McLaren Fenton Family Medicine
 Company Number: 810

Order Total Price: 56.45

Item Number: MM-103A
 Item Description: ABN English
 Revision Date: 6/2020
 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: _____

Advance Beneficiary Notice of Non-coverage (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: 1-877-486-3048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature: _____ J. Date: _____

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: ALT.Format.Services@cms.gov.

According to the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0046. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attention: Paperwork Reduction Project, Baltimore, Maryland 21244-1042.