

(B) Patient Name: _____

(C) Identification Number: _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for **(D) items** 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) items** below.

(D)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
<ol style="list-style-type: none"> 1. New Patient Exams 2. Established Patient Exams 3. Physical Therapy 4. X-Rays 5. Nutritional Supplements 6. Durable Medical Equipment 7. Orthotics & services 8. Supplies 9. Nutritional Consultation 10. Lab/Urinalysis 11. Maintenance Care Spinal Manipulation(s) 12. Extremity Manipulation 	<p>All services/supplies/items listed in column D are not a covered service when done in a chiropractic office and may not be a covered service when rendered at other places of service.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>For estimated cost (F), listed as "varies", you will be informed of your cost prior to the service being rendered. If you have questions, please don't hesitate to ask.</p> </div>	<ol style="list-style-type: none"> 1. \$45-\$235 2. \$20-\$165 3. \$10-\$55 per unit 4. N/A 5. Varies 6. Varies 7. Varies 8. Varies 9. \$135-\$235 10. Varies 11. \$35-\$55 12. \$55 each

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) items** 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.
<input type="checkbox"/> OPTION 1. I want the (D) items 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 (D) items 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 (D) items 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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According to the Paperwork Reduction Act of 1995, no persons are 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 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, 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, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.