

**A. Notifier:**


**B. Patient Name:**

**C. Identification Number:**

**Advance Beneficiary Notice of Non-Coverage (ABN)**

**NOTE:** If Medicaid doesn't pay for D. \_\_\_\_\_ below, you may have to pay.

Medicaid does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicaid may not pay for the D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
<b>OTHER:</b> _____ _____	<b>No Coverage/No Benefits</b> <b>Other:</b> _____ 	\$ _____ _____

**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 Medicaid cannot require us to do this.

<b>G. OPTIONS:</b> <b>Check only one box. We cannot choose a box for you.</b>
<input type="checkbox"/> <b>OPTION 1.</b> I want the D. _____ listed above. You may ask to be paid now, but I also want Medicaid billed for an official decision on payment, which is sent to me on a Medicaid Summary Notice (MSN). I understand that if Medicaid doesn't pay, I am responsible for payment, but I <b>can appeal to Medicaid</b> by following the directions on the MSN. If Medicaid does pay, you will refund any payments I made to you, less co-pays or deductibles. <input type="checkbox"/> <b>OPTION 2.</b> I want the D. _____ listed above, but do not bill Medicaid. You may ask to be paid now as I am responsible for payment. I <b>cannot appeal if Medicaid is not billed.</b> <input type="checkbox"/> <b>OPTION 3.</b> I don't want the D. _____ listed above. I understand with this choice I am <b>not</b> responsible for payment, and I <b>cannot appeal to see if Medicaid would pay.</b>

**H. Additional Information:**

**This notice gives our opinion, not an official Medicaid decision.** If you have other questions on this notice or Medicaid billing, call **your Case Worker or the Medicaid Consumer Hotline @ (800) 324-8680.**

Signing below means that you have received and understand this notice. You also receive a copy.

<b>I. Signature:</b>	<b>J. Date:</b>
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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.