SOUTH BEND
MEDICAL
FOUNDATION
530 N Lafayette Blvd • South Bend IN, 46601
(574) 234-4176 (800) 544-0925 • www.sbmf.org

Notifier if other than SBMF:_____

Patient Name:_____ **Identification Number:**_____
(Optional: Do not use Social Security numbers)

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for Laboratory test(s) 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 Laboratory test(s) below.

Laboratory Test(s)	Reason Medicare May Not Pay:	Estimated Cost
☐ Urine Culture ☐ Vitamin D (Specify test code) _____ ☐ PSA ☐ Pap ☐ Other_____ _____ _____	☐ Medicare does not pay for these tests as often as this (denied as too frequent) ☐ Medicare does not pay for these tests for your condition ☐ Medicare does not pay for experimental or research tests ☐ Other_____ _____	

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 **Laboratory test(s)** 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.

☐ **OPTION 1.** I want the **Laboratory test(s)** 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 **Laboratory test(s)** 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 **Laboratory test(s)** 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: If option 3 was selected, you should notify your doctor who ordered these laboratory test(s) you did not receive them.

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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Instructions for Completing ABN

1. Enter name of Notifier if other than South Bend Medical Foundation
2. Enter patient's legal name. First and last name and middle initial should be used if there is one on the beneficiary's Medicare (HICN) card. **Do not substitute** name of authorized representative if patient is unable to sign.
3. Enter patient's SBMF accession number (optional). **Medicare (HICNs) or Social Security numbers must not appear on the ABN.**
4. Enter the name of the test(s) you believe Medicare will not cover or check the appropriate preprinted test name in the box.
5. Enter the reason Medicare may not pay or check the appropriate preprinted reason in the box. There must be at least one reason applicable to each test listed. The same reason for noncoverage may be applied to multiple tests.
6. Enter the estimated cost of the test(s) you believe Medicare will not cover.
7. The patient or his or her representative must personally select an option to either receive the service and bill Medicare, receive the service and not bill Medicare, OR not to receive the service. Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.
8. Have the patient (or representative) enter the date on which he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this field, the date may be inserted by the notifier.
9. Have the patient sign their name. If the patient is unable to select an option and sign and date the ABN, an authorized representative may do so on their behalf. If a representative signs on behalf of a beneficiary, he or she should write out "representative" in parentheses after his o her signature. The representative's name should be clearly legible or noted in print.
10. The patient must receive a copy of the completed ABN.

Refer to the South Bend Medical Foundation Medical Necessity Guidebook for a complete list of tests.

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