

Patient Name: _____

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for A.SEE LISTED below, you will be held accountable for charges.

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 A.SEE LISTED below.

A.	B. Estimated Cost	C. Reason Medicare May Not Pay
<ul style="list-style-type: none">• REHABILITATIVE THERAPIES• X-RAYS• NEW PATIENT EXAMINATION• CERTAIN NUMBER OF CHIROPRACTIC ADJUSTMENTS• LIGHTFORCE LASER• DECOMPRESSION	<ul style="list-style-type: none">• \$10• \$60-\$70• \$50• \$35-\$55• \$50-\$400• BASED ON DOCTOR REFERRAL	MEDICARE ONLY COVERS CHIROPRACTIC ADJUSTMENTS AT 80% AFTER DEDUCTIBLE HAS BEEN MET. SOME MEDICARE ADVANTAGE PLANS REQUIRE PRIOR AUTHORIZATION AND WILL ONLY COVER WHAT THEY DEEM MEDICALLY NECESSARY.

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 have after reading.
- Choose the option below about whether to receive the A.SEE LISTED above.

Note: If you choose Option 1 or 2, it may help to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Choose *only one* box

- ☐ **OPTION 1.** I want the A.SEE LISTED above. I may be asked to pay 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 A.SEE LISTED above, but do not bill Medicare. I may be asked to pay now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- ☐ **OPTION 3.** I *don't want* the A.SEE LISTED above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

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 may ask to receive a copy.

Signature:	Date:
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You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/aboutus/accessibility-nondiscrimination-notice](https://www.medicare.gov/aboutus/accessibility-nondiscrimination-notice).

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.