

Pulmonary and Sleep Medicine Center of Winder

20 Satellite Dr. Ste 200, Winder, GA 30680

Phone (770) 586-0300, Fax (770) 586-0311

Beneficiary Name: _____ HIC No.: _____

Advance Beneficiary Notice of Non-coverage (ABN)

Note: If Medicare doesn't pay for services referenced below, you may have to pay.

Medicare does not pay for all services, even some care that you or I have good reason to think you need. We expect that Medicare may not pay for the services listed below:

CPT Code	Description	Estimated Cost						
1.								
2.								
3.								
4.								
5.								
<table style="width: 100%; font-size: small;"> <tr> <td style="width: 33%;">Office Use Only: PR19- Workman Comp Claim</td> <td style="width: 33%;">PR20- Third Party Liability</td> <td style="width: 33%;">PR21- MVA covered under PIP Insurance</td> </tr> <tr> <td>PR96- Non Covered Services</td> <td>PR119- Maximum benefits have been reached</td> <td>PR96- Routine Care</td> </tr> </table>			Office Use Only: PR19- Workman Comp Claim	PR20- Third Party Liability	PR21- MVA covered under PIP Insurance	PR96- Non Covered Services	PR119- Maximum benefits have been reached	PR96- Routine Care
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PR96- Non Covered Services	PR119- Maximum benefits have been reached	PR96- Routine Care						

What You Need To Do Now:

- Read this notice so that 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 to receive the services listed above.
(If you choose option 1 or 2, we may help you to use another insurance that you might have, but Medicare cannot require us to do this).

Options	Check only one box. We cannot choose the box for you
[] Option 1	I want the services listed above [list line number/s] Number: _____ I may be asked to pay now but Medicare will also be billed for an official decision on payment. I understand that if Medicare doesn't pay, I am responsible for payment. <i>I can appeal to Medicare</i> by following the directions on the MSN. If Medicare does pay, I will refund you any payments which you made, less co-pays or deductibles.
[] Option 2	I want the services listed above [list the number/s] Number: _____ Do not bill Medicare I am aware that I am responsible for the bill; <i>I cannot appeal to Medicare</i> if this claim is not submitted to Medicare.
[] Option 3	I don't want the services listed above [list the number/s] Number: _____ I understand with this choice I am not responsible for the payment and <i>I cannot appeal to see if Medicare would pay.</i>

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on the notice or Medicare billing, call 1-800-633-4227/ TTY 1-877-486-2048.

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

Signature: _____	Date: _____
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