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Date: Patient's Name: Medicaid #: MD:

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care tests or services.

We expect that Medicaid will not pay for the test(s) or services(s) that are described below. Medicaid does not pay for all your health care costs. Medicaid only pays for covered tests and services when Medicaid rules are met. The fact that Medicaid may not pay for a particular test or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicaid probably will not pay for-**

Tests or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these tests or services, knowing that you might have to pay for them yourself. Before you make any decision about your options, you should:

- **Read this entire notice carefully.**
- Ask us to explain, if you don't understand why Medicaid probably won't pay.
- Ask us how much these tests or services will cost you (**Estimated Cost:** \$ _____), in case you have to pay them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

<input type="checkbox"/> Option 1. Yes. I want to receive these tests or services. I understand that Medicaid will not decide whether to pay unless I receive these tests or services. Please submit my claim to Medicaid. I understand that you may bill me for tests or services if Medicaid decides not to pay. If Medicaid denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicaid's decision.
<input type="checkbox"/> Option 2. No. I have decided not to receive these tests or services. I will not receive these tests or services. I understand that you will not be able to submit a claim to Medicaid and that I will not be able to appeal your opinion that Medicaid won't pay.

_____ Date Signature of patient or person acting on patient's behalf

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicaid, your health information on this form may be shared with Medicaid. Your health information which Medicaid sees will be kept confidential by Medicaid.