

# Advance Beneficiary Notice of Noncoverage (ABN)

## Part A and Part B



FIRST EDITION

# Advance Beneficiary Notice of Noncoverage (ABN)

## DISCLAIMER

This booklet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This booklet was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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The Medicare Learning Network<sup>®</sup> (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's<sup>®</sup> web page at <http://www.cms.gov/MLNGenInfo> on the CMS website.

## ICD-9 NOTICE

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

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# Advance Beneficiary Notice of Noncoverage (ABN)

Beginning March 1, 2009, health care providers (including independent laboratories), physicians, practitioners, and suppliers must use the revised Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131) for all situations where Medicare payment is expected to be denied. The revised ABN replaces the ABN-G (Form CMS-R-131G), ABN-L (Form CMS-R-131L), and Notice of Exclusions from Medicare Benefits (Form CMS-20007).

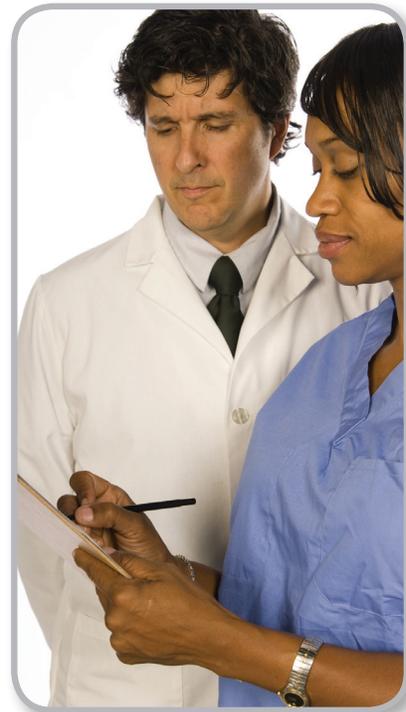
## OVERVIEW

### WHAT IS AN ABN?

An ABN is a written notice that a health care provider or his/her designee gives to a Medicare beneficiary, before outpatient items or services are rendered, when the health care provider believes Medicare will not pay for some or all of the items or services.

ABNs should only be provided to beneficiaries enrolled in Original (Fee-for-Service) Medicare. The ABN allows the beneficiary to make an informed decision about whether to receive services that he/she may be financially responsible for paying. The ABN serves as proof that the beneficiary had knowledge prior to receiving the service that Medicare might not pay. If a health care provider does not deliver a valid ABN to the beneficiary when required, the beneficiary cannot be billed for the service.

**Note:** Health care providers may not issue ABNs to shift financial liability to a beneficiary when full payment is made through bundled payments (e.g., National Correct Coding Initiative). ABNs cannot be used when the beneficiary would otherwise not be financially liable for payments for the service because Medicare made full payment.



### MEDICAL NECESSITY

Medical necessity is defined as services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member and are not excluded under another provision of the Medicare Program.

Information related to Medicare coverage, regulations, and processes is available at the Medicare Coverage Center and can be viewed at <http://www.cms.gov/center/coverage.asp> on the Centers for Medicare & Medicaid Services (CMS) website.

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## ICD-9-CM CODING

All services reported to the Medicare Program by a physician or non-physician practitioner must demonstrate medical necessity through the use of International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic coding carried to the highest level of specificity for the date of service.

## DEFINITION OF LIMITED COVERAGE

Coverage of certain items/services is limited by the diagnosis. If the diagnosis listed on the claim is not the same as one of those listed as covered for the item/service, the procedure is denied.

Limited coverage may be the result of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). The Medicare Coverage Database (MCD) at <http://www.cms.gov/mcd/overview.asp> contains all NCDs and LCDs, local policy articles, and proposed NCD decisions.

NCDs are published at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website.

The official versions of LCDs may be viewed by contractor, state, or alphabetically at <http://www.cms.gov/mcd/indexes.asp> on the CMS website.

## EXPECTATIONS

Despite the fact some health care providers may have a limited degree of contact with beneficiaries they are expected to be aware of both current national and local coverage policy. In the absence of national coverage policy, LCDs indicate which items/services will be considered reasonable, medically necessary, and appropriate. In most cases, the availability of this information indicates that the health care provider knew, or should have known, the item/service would be denied as not medically necessary.

If there is a question regarding the number of times a service has been furnished to the beneficiary within a specific period, the health care provider should clarify this information with either the beneficiary or the physician who ordered the tests.

## REASONS FOR NONCOVERAGE

Services denied by the Medicare Program as not medically necessary or reasonable fall into these general categories:

- Experimental and investigational;
- Not safe and effective;
- Limited coverage based on certain criteria;
- Obsolete tests; or
- Number of services exceeds the norm and no medical necessity demonstrated for the extra number of services.

# Advance Beneficiary Notice of Noncoverage (ABN)

## BENEFICIARY RESPONSIBILITY

Services denied by the Medicare Program as not medically necessary can be billed to the beneficiary only if the beneficiary chooses to receive the service and signs a valid ABN prior to the service(s) being furnished.

## HOW THE ABN AFFECTS THE HEALTH CARE PROVIDER

The ABN affects the health care provider in the following ways:

- When a valid ABN is given and signed, and the beneficiary elects to receive the service, the health care provider is free to bill the beneficiary for the denied services.
- If an invalid ABN is issued in situations where notice is required, the health care provider may not bill the beneficiary for the services and the provider may be held liable.
- ABNs may not be used to shift liability to a beneficiary when full payment is made through bundled payments. In general, ABNs cannot be used where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment.

## WHEN SHOULD AN ABN BE GIVEN?

### MANDATORY ABN USES

An ABN must be given when Medicare is expected to deny payment (entirely or in part) for the item or service because it is not reasonable and necessary under Medicare Program standards.

Durable Medical Equipment (DME) suppliers have additional mandatory requirements. They must issue an ABN before providing the beneficiary with items/services if:

- the provider has violated the prohibition against unsolicited telephone contacts;
- the supplier has not met supplier number requirements; or
- an advance coverage determination is required.

### VOLUNTARY ABN USES

ABNs are not required for care that is statutorily excluded or for services for which no Medicare benefit category exists. However, in these situations, health care providers can issue an ABN voluntarily. Health care providers report Healthcare Common Procedural Coding System (HCPCS) Level II modifiers to distinguish between voluntary and required ABNs.



# Advance Beneficiary Notice of Noncoverage (ABN)

## Examples of Medicare Program exclusions are:

- Personal comfort items;
- Self-administered drugs and biologicals (i.e., pills and other medications not administered by injections);
- Cosmetic surgery (unless required for prompt repair of accidental injury or for improvement of a malformed body member);
- Eye exams for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses in the absence of disease or injury to the eye;
- Routine immunizations (except influenza, pneumococcal, and hepatitis B vaccinations; these services have specific regulations regarding beneficiary responsibility);
- Physicals, laboratory tests, and X-rays performed for screening purposes (except screening mammograms, screening Pap smears, and various other mandated screening services; these services have specific guidelines regarding beneficiary responsibility and when an ABN should be obtained);
- X-rays and physical therapy provided by chiropractors;
- Hearing aids and hearing examinations;
- Routine dental services (i.e., care, treatment, filling, removal, or replacement of teeth);
- Supportive devices for the feet;
- Routine foot care (i.e., cutting or trimming corns or calluses, unless inflamed or infected; routine hygiene or palliative care or trimming of nails);
- Services furnished or paid by government institutions;
- Services resulting from acts of war; and
- Charges made to the Medicare Program for services furnished by a physician or supplier to his/her immediate relatives or members of his/her household. The following relationships are included in the definition of immediate relative: husband and wife; natural parent, child, and sibling; adopted child and adoptive parent; adopted sibling; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild; and spouse of grandparent or grandchild. By definition, members of the household include those persons sharing a common abode with the physician as part of a single-family unit, including those related by blood, marriage, or adoption; domestic employees; and others who live together as part of a single-family unit.

## ROUTINE NOTICE PROHIBITION

Health care providers are prohibited from issuing ABNs on a routine basis (i.e., where there is no reasonable basis for expectation of noncoverage). Health care providers will not violate the routine notice prohibition solely on the basis of the number of ABNs issued as long as there is a reasonable basis for issuing an ABN.

# Advance Beneficiary Notice of Noncoverage (ABN)

## TO WHOM SHOULD AN ABN BE GIVEN?

The ABN should be given to:

- The Medicare beneficiary; or
- The Medicare beneficiary's representative under applicable state or other law. A representative is an individual who may make health care and financial decisions on a beneficiary's behalf (e.g., legal guardian or someone appointed according to a properly executed "durable medical power of attorney").

## HOW TO EFFECTIVELY DELIVER AN ABN

ABN delivery is considered to be effective when the notice is:

- Delivered and comprehended by a suitable recipient;
- The correct ABN approved notice with all required blanks completed;  
**Note:** Failure to use the correct notice may lead to health care providers being found liable.
- Delivered to the beneficiary in person if possible;
- Provided far enough in advance of potentially non-covered items or services to allow sufficient time for the beneficiary to consider all available options;
- Explained in its entirety and all beneficiary-related questions are answered; and
- Signed by the beneficiary or his/her representative.



## OPTIONS FOR DELIVERY OTHER THAN IN-PERSON

In circumstances when in-person delivery is not possible, an ABN may be delivered through the following means:

- Telephone,
- Mail,
- Secure fax machine, or
- E-mail.

When delivery is not in-person, the contact must be documented in the beneficiary's records. To be considered effective, the beneficiary cannot dispute such contact. Telephone contacts must be followed immediately by either a hand-delivered, mailed, e-mailed, or faxed notice. The beneficiary or representative must sign and retain the notice and send a copy of this signed notice to the health care provider for retention in the beneficiary's record.

The health care provider must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the beneficiary does not return a signed copy, the health care provider must document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself.

# Advance Beneficiary Notice of Noncoverage (ABN)

## GENERAL NOTICE REQUIREMENTS

Other general ABN requirements include:

- A minimum of two copies, including the original, must be made so the beneficiary and health care provider each have one. The beneficiary should be given a copy of the signed and dated ABN immediately and the health care provider should retain the original copy with the beneficiary's records.
- The ABN must not exceed one page in length; however, attachments are permitted for listing additional items and services. If an attachment sheet is used, a notation such as "See Attached Page" must be inserted in the Items/Services area of the ABN. Attached pages must include the following:
  - Beneficiary's name;
  - Identification number (optional);
  - Date of issuance;
  - Table listing the additional items/services, the reasons Medicare may not pay, and the estimated costs; and
  - A space below the table in which the beneficiary inserts his/her initials to acknowledge receipt of the attachment page.
- A visually high-contrast combination of dark ink on a pale background must be used.
- Some customization of the ABN is permitted, such as preprinting information in certain blanks, to promote efficiency and to ensure clarity for beneficiaries. Customization guidelines can be found at the website listed directly below.

## COMPLETING THE ABN

The revised ABN can be found at [http://www.cms.gov/BNI/02\\_ABN.asp](http://www.cms.gov/BNI/02_ABN.asp) on the CMS website. An example of an ABN can be found on page 15 of this booklet.

The ABN is composed of five sections and ten blanks, which must appear in the following order from top to bottom on the notice:

### NOTIFIER(S) (A)

- Health care providers must place their name, address, and telephone number at the top of the notice.
- If the billing and notifying entities are not the same, the name of more than one entity may be given in the notifier area.

### PATIENT NAME (B)

- Health care providers must enter the first and last name of the beneficiary receiving the notice. The middle initial should also be used if there is one on the beneficiary's Medicare card.

# Advance Beneficiary Notice of Noncoverage (ABN)

## IDENTIFICATION NUMBER (C)

- Medicare numbers Health Insurance Claim Numbers (HICNs) or Social Security numbers **must not** appear on the notice.
- Insertion of an identification number is optional for health care providers.

## BODY (D)

- Health care providers must list the general description of items or services believed to be non-covered on the blank line of the “NOTE.”

## TABLE (D, E, F)

### • **First Block (D)**

- Health care providers must list the specific items or services believed to be non-covered.
- In the case of partial denials, health care providers must list the excess component(s) of the item or service for which denial is expected.

### • **Reason Medicare May Not Pay (E)**

- Health care providers must explain in beneficiary-friendly language why they believe each item or service may not be covered by Medicare. Commonly used reasons for noncoverage are:
  - Medicare does not pay for this test for your condition.
  - Medicare does not pay for this test as often as this (denied as to frequency).
  - Medicare does not pay for experimental or research use tests.

**Note:** To be a valid ABN, there must be at least one reason applicable to each item or service listed. The same reason for noncoverage may be applied to multiple items.

### • **Estimated Cost (F)**

- Health care providers must complete the Estimated Cost blank to ensure the beneficiary has all available information to make an informed decision about whether to obtain potentially non-covered services.
- Health care providers must make a good faith effort to insert a reasonable estimate for all the items or services listed. In general, it is expected that the estimate will be within \$100 or 25 percent of the actual costs, whichever is greater. Examples of acceptable estimates include, but are not limited to, the following:
  - For a service that costs \$250:
    - Between \$150 – \$300.
    - No more than \$500.
  - Multiple items or services that are routinely grouped can be bundled into a single-cost estimate.

# Advance Beneficiary Notice of Noncoverage (ABN)

## OPTIONS 1, 2, OR 3

The beneficiary or his/her representative must choose only one of the three options listed.

- **Option 1:**
  - This allows the beneficiary to receive the item or services at issue and requires the health care provider to submit a claim to Medicare. This will result in a payment decision that can be appealed.
- **Option 2:**
  - This option allows the beneficiary to receive the non-covered items or services and pay for them out-of-pocket. No claim will be filed and Medicare will not be billed. Therefore, there are no appeal rights associated with this option.
  - Health care providers will not violate mandatory claims submission rules under Section 1848 of the Social Security Act when a claim is not submitted to Medicare at the beneficiary's written request when selecting this option.
- **Option 3:**
  - This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and, thus, there are no appeal rights.

## ADDITIONAL INFORMATION (H)

Health care providers may use this space to provide additional clarification they believe will be of use to beneficiaries. For example:

- A statement advising the beneficiary to notify his/her health care provider about certain tests that were ordered but not received;
- An additional dated witness signature; or
- Other necessary annotations:
  - Annotations will be assumed to have been made on the same date as that appearing with the beneficiary's signature unless a separate date is included with the annotation.

## SIGNATURE/DATE BOX (I, J)

Once the beneficiary reviews and understands the information contained in the ABN, the Signature/Date Box is to be completed by the beneficiary or representative.

- **Signature:**
  - The beneficiary or representative must sign the notice to indicate that he/she received the notice and understands its contents. If a representative signs, he/she should indicate "representative" after his/her signature.
- **Date:**
  - The beneficiary or representative must write the date he/she signed the ABN. If the beneficiary has physical difficulty writing and requests assistance in completing this blank, the date may be inserted by the health care provider.

# Advance Beneficiary Notice of Noncoverage (ABN)

## OTHER THINGS TO CONSIDER WHEN COMPLETING THE ABN

### BENEFICIARY CHANGES HIS/HER MIND

If after completing and signing the ABN the beneficiary changes his/her mind, the health care provider should present the previously completed ABN to the beneficiary and request that he/she annotate the original ABN. The annotation must include a clear indication of his/her new option selection along with his/her signature and date of annotation. In situations where the health care provider is unable to present the ABN to the beneficiary in person, the health care provider may annotate the form to reflect the beneficiary's new choice and immediately forward a copy of the annotated notice to the beneficiary to sign, date, and return.



**Note:** In both situations, a copy of the annotated ABN must be provided to the beneficiary as soon as possible.

### BENEFICIARY REFUSES TO COMPLETE OR SIGN THE NOTICE

If the beneficiary refuses to choose an option and/or refuses to sign the ABN, the health care provider should annotate the original copy of the ABN indicating the refusal to sign and may list witness(es) to the refusal on the notice, although this is not required. If a beneficiary refuses to sign a properly delivered ABN, the health care provider should consider not furnishing the item/service, unless the consequences (health and safety of the beneficiary, or civil liability in case of harm) are such that this is not an option.

### ABN FOR AN EXTENDED COURSE OF TREATMENT

An ABN is not needed every time for an extended course of treatment. A single ABN covering an extended course of treatment is acceptable, if the ABN identifies all items/services and duration of the period of treatment for which the health care provider believes Medicare will not pay. If the health care provider believes Medicare will deny additional services furnished during the course of treatment, a separate ABN is needed.

A single ABN for an extended course of treatment is valid for one year. If the course of treatment extends beyond one year, a new ABN is needed for the remainder of the course of treatment.

Once the beneficiary has signed the ABN, it cannot be modified or revised. When the beneficiary needs to be notified of new information, a new ABN must be given.

# Advance Beneficiary Notice of Noncoverage (ABN)

## ABN IN A MEDICAL EMERGENCY

An ABN should not be obtained from a beneficiary in a medical emergency or otherwise under great duress (i.e., when circumstances are compelling and coercive). ABN usage in the emergency room may be appropriate in some cases where the beneficiary is medically stable with no emergent health issues.

## HOW LONG SHOULD AN ABN BE KEPT ON FILE?

In general, the ABN should be kept for five years from discharge/completion of delivery of care when there are no other applicable requirements under State law. Health care providers are required to keep a record of the ABN in all cases, including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the notice.

## WHAT HAPPENS WHEN MULTIPLE ENTITIES ARE INVOLVED IN RENDERING CARE?

When multiple entities are involved in rendering care, it is not necessary to give separate ABNs. Either party involved in the delivery of care can issue the ABN when:

- There are separate “ordering” and “rendering” providers (e.g., a physician orders a laboratory test and an independent laboratory delivers the ordered tests);
- One health care provider delivers the “technical” component and the other the “professional” component of the same service (e.g., radiological test that an independent diagnostic testing facility renders and a physician interprets); or
- The entity that obtains the signature on the ABN is different from the entity that bills for the service (e.g., when one laboratory refers a specimen to another laboratory, which then bills Medicare for the test).



Regardless of who gives the notice, the billing entity will always be held responsible for effective delivery. In these situations, it is permissible to enter the names of more than one entity in the header of the notice.

## LACK OF ABN NOTIFICATION

A health care provider will likely have financial liability for items/services if he/she knew or should have known that Medicare would not pay and fails to issue an ABN when required or issues a defective ABN. In these cases, the health care provider cannot collect funds from the beneficiary and is required to make prompt refunds if funds were previously collected.

# Advance Beneficiary Notice of Noncoverage (ABN)

## COLLECTION OF FUNDS AND REFUNDS

A beneficiary's agreement to be responsible for payment on an ABN means that the beneficiary agrees to pay for expenses out-of-pocket or through any insurance other than Medicare. The health care provider may bill and collect funds for non-covered items/services immediately after an ABN is signed.

If Medicare ultimately denies payment, the health care provider retains the funds collected. However, if Medicare pays all or part of the claim for items/services previously paid by the beneficiary or if Medicare finds the health care provider liable, the health care provider must refund the beneficiary the proper amount in a timely manner. Refunds are considered timely when made within 30 days of the notice of the claim denial from Medicare or within 15 days after a determination on an appeal if an appeal is made.

## CLAIM REPORTING MODIFIERS

When the previous instructions have been completed, the following modifiers should be used to notify Medicare:

**GA Waiver of Liability Statement Issued as Required by Payer Policy**

This modifier is used to report a required ABN was issued for a service and is on file. A copy of the ABN does not have to be submitted but must be made available upon request.

**GX Notice of Liability Issued, Voluntary Under Payer Policy**

This modifier is used to report a voluntary ABN was issued for a service.

**GY Notice of Liability Not Issued, Not Required Under Payer Policy**

This modifier is used to report that an ABN was not issued because the item or service is statutorily excluded or does not meet the definition of any Medicare benefit.

**GZ Item or Service Expected to Be Denied as Not Reasonable and Necessary**

This modifier is used to report an ABN was not issued for a service.

# Advance Beneficiary Notice of Noncoverage (ABN)

## EXAMPLE OF AN ABN

An example of ABN Form CMS-R-131 is provided below.

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn't pay for (D) \_\_\_\_\_ 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 (D) \_\_\_\_\_ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

#### 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 Medicare cannot require us to do this.

#### (G) OPTIONS:

Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the (D) \_\_\_\_\_ 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 (D) \_\_\_\_\_ 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 (D) \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

#### (H) Additional Information:

**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.

(I) Signature:

(J) Date:

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.

Form CMS-R-131 (03/08)

Form Approved OMB No. 0938-0566

# Advance Beneficiary Notice of Noncoverage (ABN)

## RESOURCES FOR ADDITIONAL INFORMATION

The revised ABN manual instructions and ABN Form CMS-R-131 are available at [http://www.cms.gov/BNI/02\\_ABN.asp](http://www.cms.gov/BNI/02_ABN.asp) on the CMS website.

The Medicare Coverage Database (MCD) is dedicated to assisting health care providers in the latest information related to NCDs and LCDs, local policy articles, and proposed NCD decisions. The MCD is available at <http://www.cms.gov/mcd/overview.asp> on the CMS website.

Information related to coverage and important links are available at the Medicare Coverage Center at <http://www.cms.gov/center/coverage.asp> on the CMS website.

The online CMS Internet-only Manuals (IOMs) include CMS' program issuances, day-to-day operating instructions, policies, and procedures based on statutes, regulations, guidelines, models, and directives. To view the NCD Manual, visit the IOM web page at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website.

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