ABN Form Instructions

The Medicare ABN form is a requirement for Medicare patients to complete each calendar year. By signing this form, you are verifying that you have been informed about the cap that Medicare puts on each patient's combined physical therapy benefits each calendar year. The cap for each calendar year is $1,860. **BY CHECKING "OPTION 1" AND SIGNING THE FIRST FORM,** you are acknowledging this cap and that once it is exceeded you or your secondary insurance may be responsible for all treatments that have exceeded the Medicare cap.

BY CHECKING "OPTION 1" AND SIGNING THE SECOND FORM, you are allowing us to charge Medicare directly for all possible treatment codes that will be used over the course of your therapy at Great Basin Physical Therapy and Performance Center. If you would prefer to handle the claims yourself, and NOT allow us to bill Medicare for your treatment, then please check any of the other options.

These forms are kept in your chart for reference purposes, and as proof that you have acknowledged Medicare's cap and policies for this calendar year.

Patient Name:_____ **Identification Number:**_____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below (page 2), 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 items listed or checked in the box below.

Options:	**Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the _____listed below. 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 _____listed below, 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 _____ listed below. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

RESET FORM

Listed or Checked Items Only:	Physical Therapy over the Medicare Cap AND Occupational Therapy over the Medicare Cap	**$1,900.00** **$1,900.00**	Per Calendar year Per Calendar year
Reason Medicare May Not Pay:	Effective January 1, 2013, Medicare has limited Outpatient Physical Therapy and Occupational Therapy To a cap of **$1,900.00** per calendar year	Great Basin Physical Therapy and Performance Center, LLC. Will note in each patient chart the amount Medicare will pay for each visit to insure	Great Basin Physical Therapy and Performance Center, LLC. Will also inform each patient when they are close to exceeding the Medicare Cap.
Estimated Cost:	Any charges over the Medicare Cap that does Not qualify for additional treatment	Patient does not exceed Medicare's cap.	

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 checked items listed in the first box above.

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

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.

Signature:	**Date:**

Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566

RESET FORM

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:

Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566

RESET FORM