McLaren Business Products

McLaren Print System Order

Order No: 6349
Order Date: 2014-10-08
User: Michele Lubick
Phone: 586-263-0320

Ship Location: McLaren Macomb Family Medicine-Michele
16700 21 Mile Rd., Suite 101
Macomb, MI 48044
Forms
Quantity: 100
Paragon Dept No: 71600
Dept Name: McLaren Macomb Family Medicine
Company Number: 810

Order Total Price: 18.35

Item Number: MM-103A (8931) English
Item Description: ABN (McLaren Macomb Family Medicine Suite 101)
Revision Date:
Print: 1 sided black and white
Paper: 3 Part (White, Yellow, Pink)
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLAREN MACOMB FAMILY MEDICINE

Patient Name:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

Checked Items Daily	Items or Services	Reason Medicare May Not Pay:	Estimated Cost:
☐	[illegible]	Medicare does not pay for this service for your condition	$37.00
☐	Chest X-ray	Medicare does not pay for this service for your condition	$87.00
☐	EKG, complete	Medicare does not pay for this service for your condition	$41.00
☐	Hemoccult	Medicare does not pay for this service for your condition	$15.00
☐	Urinalysis	Medicare does not pay for this service for your condition	$11.00
☐	PAP Smear	Medicare does not pay for this service as often as this	$70.00
☐	OTC Exam	Medicare does not pay for this service as often as this	$119.00
☐			
☐			
☐			
☐			

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 ID _____ 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 register us to do this.

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

☐ **OPTION 1.** I want the _____ listed above. You may ask us 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 coinsurance or deductibles.

☐ **OPTION 2.** I want the _____ 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 _____ listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

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:

WHITE: RECORD YELLOW: PATIENT PINK: ROUTER