

**MEDICARE PATIENTS**

Dear Patient:

MEDICARE will only pay for services that are determined to be “reasonable and necessary”.

This means they will **NOT PAY FOR ROUTINE VISITS OR LAB WORK.** If your visit is **ROUTINE**, please sign below:

BENEFICIARY AGREEMENT:

My physician has notified me that MEDICARE is likely to deny payment for Services for the reasons stated above. If Medicare denies payment, I agree to be personally and fully responsible for payment.

(Medicare Beneficiary Patient) Date

**\* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \* \***

IF YOU ARE BEING SEEN FOR A SPECIFIC PROBLEM, PLEASE ASK THE DOCTOR/NURSE PRACTITIONER TO CHECK A DIAGNOSIS AND PROBLEM VISIT ON YOUR ENCOUNTER FORM.

**IF THIS IS NOT DONE, IT WILL BE SUBMITTED AS ROUTINE AND YOU WILL BE RESPONSIBLE FOR PAYMENT**

WH A-8

Reviewed 01-2005, 10-2008

Reviewed 2/23/17



Dear Medicare Patient:

You are here today for your yearly preventative examination.

There are two components to your examination:

1. PELVIC AND BREAST EXAMINATION
2. PAP SMEAR

Medicare covers these exams every TWO years.

If you have a secondary insurance, we will submit the claim to them. However, your secondary insurance may or may not pay for the visit. You will be responsible for charges not covered by Medicare or your secondary insurance.

The enclosed form is required by Medicare. Your signature indicates that you are aware that Medicare will pay only a portion of your Preventative Annual Exam every two years.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WH A-8

Reviewed 01-2005, 08-2008

Revised 12-23-08, 07-2015

Reviewed 2/23/17

# A. Notificante:

# B. Nombre del paciente: C. Número de identificación:

Notificación previa de NO-cobertura al beneficiario (ABN)

NOTA: Si Medicare no paga D. a continuación, usted deberá pagar.

Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, están justificados. Prevemos que Medicare no pagará D. a continuación.

| D. | **E.Razón por la que no está cubierto**  por Medicare: | **F. Costo**  pestimado |
| --- | --- | --- |
|  |  |  |

**Lo que usted necesita hacer ahora:**

* Lea la presente notificación, de manera que pueda tomar una decisión fundamentada sobre la atención que recibe.
* Háganos toda pregunta que pueda tener después de que termine de leer.
* Escoja una opción a continuación sobre si desea recibir D. mencionado anteriormente.

Nota: Si escoge la opción 1 ó 2, podemos ayudarlo a usar cualquier otro seguro que

tal vez tenga, pero Medicare no puede exigirnos que lo hagamos.

| **G. Opciones: Sírvase marcar un recuadro solamente. No podemos escoger un recuadro por usted.** |
| --- |
| **☐ OPCIÓN 1.** Quiero **D.**  mencionado anteriormente. Puede cobrarme ahora, pero también deseo que se cobre a Medicare a fin de que se expida una decisión oficial sobre el pago, la cual se me enviará en el Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable por el pago, pero **puedo apelar a Medicare** según las instrucciones en el MSN. Si Medicare paga, se me reembolsarán los pagos que he realizado, menos los copagos o deducibles.  **☐ OPCIÓN 2.** Quiero **D.**  mencionado anteriormente, pero que no se cobre a Medicare. Puede solicitar que se le pague ahora dado que soy responsable por el pago.  **No tengo derecho a apelar si no se le cobra a Medicare.**  **☐ OPCIÓN 3.** No quiero **D.**  mencionado anteriormente. Entiendo que con esta opción no soy responsable por el pago y **no puedo apelar para determinar si pagaría Medicare.** |

H. Información adicional:

**En esta notificación se da a conocer nuestra opinión, no la de Medicare.** Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Al firmar abajo usted indica que ha recibido y comprende la presente notificación. También se le entrega una copia.

| I. Firma: | J. Fecha: |
| --- | --- |

De conformidad con la Ley de reducción de los trámites burocráticos de 1995, nadie estará obligado a responder en todo pedido para recabar información a menos que se identifique con un número de control OMB válido. El número de control OMB válido para esta recolección de información es 0938-0566. El tiempo necesario para completar esta solicitud de información se calcula, en promedio, 7 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar en fuentes de datos existentes, recabar los datos necesarios y llenar y revisar los datos recogidos. Si tiene comentarios sobre la precisión del cálculo del tiempo o sugerencias para mejorar el presente formulario, sírvase escribir a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Formulario CMS-R-131 (03/11) Formulario aprobado OMB No 0938-0566

# A. Notifier:

# B. Patient Name: C. Identification Number:

## **Advance Beneficiary Notice of Noncoverage (ABN)**

## NOTE: If Medicare doesn’t pay for D. **Services** 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 |
| --- | --- | --- |
| Pelvic and breast examination  Pap Smear ( If performed ) | Medicare pays every two years | $114.36  $112.62 |

**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.** **Services** 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. Services** 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. Services** 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. Services** 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 (03/11) Form Approved OMB No. 0938-0566