Clinton REGIONAL HOSPITAL

Advance Beneficiary Notice for Medicare Patients

Last name	First name	DOB

Address	SSN

Secondary insurance information, if any (list name, policy #, group #, plan, insured's name)

Tertiary insurance information, if any (list name, policy #, group #, plan, insured's name)

PATIENT NOTICE

If Medicare or any supplemental insurance I may have does not pay for the care and services I receive, I may have to pay. I understand that Medicare and any other insurance I may have does not pay for everything. Even some care/services that I or my health care provider have reason to think I need, may not be paid for by my insurance.

The following care and services may not be covered by insurance. Other care and services that you may receive not listed below may not be covered.

Evaluation & Management: _____
Diagnostics: _____
Procedures: _____
Other: _____

Services that Medicare or other insurances may not pay for and possible reasons for non-payment: [office staff use only]

Services are not covered by the insurance
Services are deemed not medically necessary
Services are considered experimental
Service frequency exceeds cap
Provider is not authorized
Other:_____

INFORMATION FROM YOUR PHYSICIAN

Read this notice so you can make informed decision about your care. After you finish reading, ask us any questions you may have.
Choose an option below about whether to receive the services listed above.

OPTIONS: (Check only one box)

OPTION 1. I want the services listed above and I want Medicare and any supplemental insurance to be billed. I understand if my insurance doesn't pay, I am responsible for payment, but I can appeal Medicare or my supplemental insurance carrier(s). If my insurance carrier does pay, I will be refunded any payments I made to my provider, less co-pays and deductibles.

OPTION 2. I want the services listed above, but do not bill my insurance. I will be asked to pay for the services now. I cannot appeal if my insurance is not billed.

OPTION 3. I do not want the services listed above. I understand that with this chouice I am not responsible for payment and I cannot appeal to see if my insurance would pay. I may also be asked to sign an informed refusal document by my health care provider

ADDITIONAL INFORMATION

This notice is an opinion, not an official coverage decision. If you have coverage questions, call your insurance carrier on the number given on the back of the card. Signing below means that you agree to adhere to the terms of this notice.

Patient Signature:_____ Print Name:_____Date :_____