3805 Edwards Road, Suite 100
Cincinnati, OH 45209
513-631-6963

Date: _____ Patient's Name: Medicare # (HICN): Pending

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

Medicare (and/or your Insurance Carrier) will not pay for the item(s) or service(s) that are described below. Medicare (and/or your Insurance Carrier) does not pay for all of your health care costs. Medicare (and/or your Insurance Carrier) only pays for covered items and services when Medicare (and/or your Insurance Carrier) rules are met. The fact that Medicare (and/or your Insurance Carrier) will not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare (and/or your Insurance Carrier) will not pay for –**

Items or Services:
Annual subscription fee for non-covered health care services.
Because:
Medicare (and/or your Insurance Carrier) will not pay for services that are not under their description of covered services. Participation in a limited enrollment practice, and non-covered health care services are not recognized by Medicare (and/or your Insurance Carrier) as covered services.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you have to pay for them yourself. Before you make any decision about your options, you should:

- **Read this entire notice carefully.**
- Ask us to explain, if you don't understand why Medicare (and/or your Insurance Carrier) won't pay.
- Ask us how much these items or services will cost you **(Cost: $1,500 per year**), as you have to pay for them yourself.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**
I understand that Medicare (and/or my Insurance Carrier) will not to pay for these services. I agree to be personally and fully responsible for payment.

☐ **Option 2. NO. I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare (and/or my Insurance Carrier) and that I will not be able to appeal your opinion that Medicare (and/or my Insurance Carrier) won't pay.

_____ _____
Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare (and/or your Insurance Carrier), your health information on this form may be shared with Medicare (and/or your Insurance Carrier). Your health information which Medicare (and/or your Insurance Carrier) sees will be kept confidential by Medicare (and/or your Insurance Carrier).