



Advance Beneficiary Notice

Patient Name _____ Patient Number _____

Payor _____ Date of Notice _____

Payor will only pay for services that it determines to be reasonable and necessary under Section 1862(a)(1) of the Medicare law OR medically necessary under the applicable Payor policies.

If Payor determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare Program Standards OR "not medically necessary" under the applicable Payor's standards, Payor will deny payment of that service. If payor determines that a service or supply is "deluxe" under the applicable Payor's standards, Payor may deny the service or supply entirely or only make payment for the standard service or supply. I believe that in your case, Payor is likely to deny payment or only make payment for the standard service or supply for the following service(s) for the following reason(s):

Description of Services Likely to be Denied and or Paid at Standard	Reason for Denial of Deluxe Supply	Approximate Patient Out-of-Pocket Cost

Beneficiary Agreement to PAY:

"I have been notified by my physician/supplier that it believes that, in my case, Payor is likely to deny payment for the services identified above or only make payment for the standard service or supply, for the reasons stated. I understand that I have the right to decide whether or not to receive the service identified above. I have decided to receive the service. If Payor denies payment, or makes a payment for the standard service or supply, I agree to be personally and fully responsible for payment. If Payor makes payment for a standard service or supply, I agree to be personally and fully responsible for the difference between Payor's payment and Hearing Center, Inc.'s full billed charge."

Patient's Signature _____ Date of Signature _____

Beneficiary Refusal to Receive Item or Service at Own Expense:

"I have been notified by my physician/supplier that it believes that, in my case, Payor is likely to deny payment for the item or service identified above, for the reasons stated. I understand that I have the right to decide whether or not to receive this item or service identified above. I have decided not to receive the item or service, since I am not willing to be personally responsible for payment."

Patient's Signature _____ Date of Signature _____

If you refuse to sign either one and you still demand and receive the service anyway, you probably will be personally and fully responsible for payment. By "personally and fully responsible for payment," we mean that you will have to either pay out of pocket or by any other insurance coverage that you may have. Patient refused to sign Advance Beneficiary Notice (ABN) after reading:

Witness _____ Date _____