ADVANCE BENEFICIARY NOTICE (ABN)

PATIENT NAME: ________________________________ MEDICARE # (HICN): ____________________________

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

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may 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. In most cases, Medicare probably will not pay for –

Item or Service:	Reason:
Routine Eye Health Exam:	Medicare only covers eye health exams where there is a specific medical diagnosis. Examples are glaucoma, cataracts, diabetic and hypertensive ocular conditions or other specific eye diseases or injuries.
Refraction:	Medicare does not cover the cost to determine your prescription. This is an additional service by the doctor.
Dilation:	Medicare only covers dilation when medically necessary, see above.
Optomap:	This is an alternative to dilation it is usually denied by Medicare. You will need to pay for this service on the day you receive it. If we receive payment from Medicare, we will reimburse you immediately.
Eyeglasses	Medicare only covers eyeglasses after cataract surgery. They cover 1 pair within 90 days of surgery. The coverage limit is a maximum of 2 pair per lifetime.
Low vision therapy materials:	Medicare will cover the exam to determine if you need low vision therapy, however they do not cover any of the equipment needed for the therapy.

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 will have to pay for them yourself. Before you make a decision about your options, you should READ THIS ENTIRE NOTICE CAREFULLY.

- Ask us to explain if you do not understand why Medicare probably will not pay for a particular service.
- Ask us about the cost of these items or services (Estimated cost: $____________), for the event you may have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION below. CHECK or CIRCLE **ONE, then SIGN & DATE** below.

Option1. YES. I want to receive these services.

I understand that Medicare will not consider these services for payment until I have received the service. I understand that I have to pay for these services up front while Medicare is making a decision. If Medicare does pay, you will refund me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay for these services up front. I understand that I can appeal Medicare's decision.

Option2 NO. I do not want to receive these services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date: ____________________________ Signature: ____

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, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.