



Medicare Advance Beneficiary Notice (ABN)

Patients Name _____ Medicare Number _____ Date _____

Medicare is your primary health insurance and, for your convenience, our office bills Medicare for your office visits, tests and materials. Medicare then reviews all submitted claims and, if approved, reimburses 80% of the approved amount. The remaining **20% (the co-payment) is your responsibility** as the Medicare beneficiary.

Medicare has a **yearly deductible of \$135.00** that takes effect each January. If our office is the first to submit Medicare claims for you each year, Medicare will notify us that you have not yet met your deductible for the year. Medicare will not pay for your allowable fees until the deductible is met.

Medicare does not pay for refractive services, which is the part of your eye exam that determines your prescription. Medicare will only pay for the medical part of the exam, if a medical diagnosis is made.

Medicare does not cover glasses or contact lenses except for one time after cataract surgery. Medicare will cover towards standard frame, and standard lenses. Medicare does not cover deluxe frames or lens features.

Medicare only pays for covered products or services when medicare rules are met. The fact that medicare may not pay for a product or service does not mean that you should not receive it. There may be good reason that your doctor recommended it. We expect that Medicare will not pay for the following items or services:

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Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these products or services, knowing that you may have to pay for them yourself.

1. Read this entire notice carefully.
2. Ask us to explain, if you don't understand why Medicare probably won't pay.
3. If you have to pay for these items or services yourself, the **estimated cost is \$** _____
4. Choose one option below. Check on box. Sign and date your choice.

Option 1. YES, I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that I will pay for these items or service. If Medicare does pay, you will refund any payments I make to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment, either out-of-pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

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 that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

