# Medicare Advance Beneficiary Notice (ABN)

Patient's Name: Medicare #: 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 $110 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 part of your eye exam that determines your prescription. Medicare will only pay if a medical diagnosis is made.
- Medicare does not cover glasses or contact lenses unless you have had cataract surgery. Medicare will cover your lenses one time, plus one standard frame, per operation. Medicare does not cover deluxe frames or lens treatments, such as scratch coating, UV coating (unless medically necessary), or oversize lenses.
- Medicare only pays for covered items or 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. We expect that Medicare will not pay for the item(s) or service(s) that are described below.

Items or Services:

Because:

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 might have to pay for them yourself.

1. Read this notice carefully.
2. Ask us to explain if you don't understand something.
3. If you have to pay for these items or services yourself, the estimated cost is $
4. Choose one option. Check one box below. 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 you may bill me in part, or in full for items or services that I received. 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 patient's responsible party)

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