SPECTRUM HEALTH
PO Box 2127,
Grand Rapids, MI 49502
800.968.0145

# Billing/Consent ADVANCE BENEFICIARY NOTICE (ABN) OF NONCOVERAGE - MEDICARE ADVANTAGE PLAN (MAP)

Patient Name
DOB
MRN
Physician
FIN

## Advance Beneficiary Notice of Non-Coverage (ABN)

**NOTE:** You are covered by a **Medicare Advantage Plan (MAP)** that may not pay for the service(s) listed below – meaning that you may have to pay for them yourself. Your coverage does not pay for everything, even some care that you or your health care provider believe that you need. We expect that your MAP **may** not pay for these services, based on their guidelines:

| 1. Description of Service(s) | 2. Reason Your MAP May Not Pay: | 3. Estimated Cost |
|---|---|---|
| | | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the service(s) listed above in **Box 1**

**Note:** If you choose Option A or B, we may help you to use any other insurance plan that you might have, but your MAP cannot require us to do this.

**OPTIONS: Please check only one box. We cannot choose a box for you.**

☐ **OPTION A.** I want the service(s) listed above. You may ask to be paid now, but I also want my MAP plan billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my MAP plan does not pay, I am responsible for payment, but **I can appeal to the plan** by following the directions on the EOB**.** If the plan does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION B.** I want the service(s) listed above, but do not bill my MAP. You may ask to be paid now for these services as I am responsible for payment. **I cannot appeal if my MAP is not billed**.

☐ **OPTION C.** I do **not** want the service(s) listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my MAP would pay.**

**Additional Information:**

Advanced Radiology Services Professional Estimated Fee $_____

This notice gives our opinion on what may happen, and is not an official Medicare Advantage decision. If you have other questions on this notice or MAP billing, please contact your MAP.

Signing below means that you have received and understand this notice. You also receive a copy.

| Signature: | Date: |
|---|---|
| | |

Spectrum Health – Advanced Beneficiary Notice (Medicare Advantage) – October 2012

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

**TIME** _____ **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

**White – Chart** **Yellow – Patient**

DO NOT MARK BELOW THIS LINE — BARCODE ZONE — DO NOT MARK BELOW THIS LINE