Allina Health LABORATORY

2925 Chicago Ave
Minneapolis, MN
612-262-6000 or 800-958-5077

A. Notifier: Enter your facility name, address and telephone number here

B. Patient Name: Place the patient/beneficiary name here **C. Identification Number:** Optional field

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____________below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**____________below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Enter the name of the specific non-covered service(s) here, as well as in the two blanks labeled D above and one blank labeled D below	Enter the reason that Medicare may not cover the service(s). Three examples are: • Medicare does not pay for this test for your condition • Medicare does not pay for this test as often as this • Medicare does not pay for experimental or research use tests There must be one reason listed for each non-covered service listed	Enter a good faith estimate of the cost of the uncovered service(s)

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 **D.**____________listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

After reading the "*What you need to do now*", the patient/ beneficiary or their representative must check one box in area G indicating their decision.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**____________listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____________listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**____________listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

If they refuse to make a choice, the notice should be annotated "Beneficiary refuses to choose an option"

H. Additional Information:

Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature: Patient/beneficiary or representative signature is required. If a representative signs, they must include (representative) behind their signature.	J. Date: Patient/beneficiary or representative must date. The date may be inserted by the notifier if the patient has difficulty.

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