

DRAFT ONLY—NOT FOR OFFICAL USE

Skilled Nursing Facility Advance Beneficiary Notice

Patient Name: _____ Medicare # (HICN): _____

The Skilled Nursing Facility believes that Medicare is not likely to pay for the care described below. **Beginning on** _____, you may have to pay out of pocket for these items or services, or you may have other insurance that may cover these costs.

Items/Services:	Estimated Cost:
Because:	

Ask us to explain, if you don't understand why we believe that Medicare may not pay for the items or services as listed above.

IMPORTANT: You need to make a choice about receiving these items and/or services.

You must choose only **one** of the three options below, since we believe Medicare may not pay for the items and/or services listed above:

<p><input type="checkbox"/> 1. Do not provide me with the items and/or services listed above, because I do not want to be billed. I understand that I have no Medicare appeal rights, since I will not receive the items and/or services listed above.</p> <p><input type="checkbox"/> 2. Please provide me with the items and/or services listed above, and I agree to pay myself, since I don't want to have a claim submitted to Medicare or any other insurance I have. I understand that I have no Medicare appeal rights since a claim won't be submitted.</p> <p><input type="checkbox"/> 3. Please provide me with the items and/or services listed above. I want a claim submitted. I understand that if my claim is denied, I will have Medicare appeal rights. Send the claim to (Please check all that apply below):</p> <p><input type="checkbox"/> Medicare</p> <p><input type="checkbox"/> my other insurance: _____</p> <p>I agree to pay for the items or services myself if Medicare or my other insurance doesn't pay the claim. See Page 2 for important information about your appeal rights.</p>
--

Your signature below means that you have received this notice and you understand that we believe that Medicare is not likely to pay for the items and/or services described above.

Patient's or Authorized Representative's Signature	Date
Skilled Nursing Care Provider's Signature	Date

Please read and sign this form. Return it to the address at the top of this notice.

DRAFT ONLY—NOT FOR OFFICIAL USE

IMPORTANT: PLEASE READ THE FOLLOWING INFORMATION REGARDING YOUR APPEAL RIGHTS

An **appeal** allows you to ask Medicare to review certain decisions regarding your care, including Medicare payment.

You must receive the items or services, and request that a claim be submitted in order to ask for an appeal.

IMPORTANT: The options on the first page of this notice affect your appeal rights.

- If you select **Option 1** or **Option 2** on Page 1 of this notice, a claim will not be submitted and you will not be able to make an appeal to Medicare.
- If you select **Option 3**, a claim will be submitted to either Medicare or your other insurance. You must select this option in order to have a claim submitted. If you choose to have a claim submitted to Medicare, the following information explains how your claim will be handled:
 - We will notify you once a Medicare Part A claim has been submitted.
 - Once a claim has been submitted, you will receive a Medicare Summary Notice (MSN) notifying you of Medicare's official payment decision.
 - If the MSN indicates that Medicare won't pay all or part of your claim, the MSN will explain how to make an appeal.
 - If you do not receive a MSN, you can call Medicare at: **1-800-633-4227/TTY: 1-877-486-2048**.

If you ask to have a claim filed, the Skilled Nursing Facility cannot charge you for any Part A care, such as room and board and medical care until you have received an official decision from Medicare. If you do not have Part A coverage and are only receiving items and/or services usually covered by Part B, you may be asked to pay at the time you receive services. These payments must be refunded to you if Medicare or other insurance later provides payment on your behalf. Even if Medicare is billed, you are still responsible for any other costs that you would normally have to pay, such as daily coinsurance and the costs for services and supplies Medicare never pays for, such as having a telephone or television in your room.

You or your authorized representative must initial here to acknowledge that you have read and understood the information on this page regarding your appeal rights. _____