Form Approved
OMB No. 0938-XXXX

Notice of Exclusions from Medicare Benefits Home Health Agency (NEMB-HHA)

Date of Notice:_____

There are home health items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,** personally or through any other insurance that you may have.

Medicare will not pay for:

Because of the following Medicare Exclusion:

- ❑ Services that would not be covered for inpatients.
- ❑ Medical social services to family members.
- ❑ Services covered under the ESRD program.
- ❑ Dietician or nutritionist visits.
- ❑ Housekeeping services (cooking, shopping, Meals on Wheels, cleaning, laundry).
- ❑ Prosthetic devices (not including certain catheters, ostomy bags, catheter supplies, and other supplies relating to ostomy).
- ❑ Personal care given by home health aides, like bathing, using the toilet, or help in getting dressed – when this is the only care you need.
- ❑ Items or services furnished without a physician's order or certification.
- ❑ Outpatient occupational and physical therapy services furnished incident to a physician's services that do not meet certain standards and conditions for therapists.
- ❑ Drugs and biologicals.
- ❑ Transportation.
- ❑ 24 hour daily care at home.
- ❑ Respiratory therapist visits.
- ❑ **Other**: _____

_____
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The purpose of this notice is to help you make an informed choice about whether or not to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost:** $_____).

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN** AND **DATE** THIS NOTICE.

❑ **Option 1. YES** **I want to receive these items or services.** I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have.

❑ **Option 2. NO** **I have decided not to receive these items or services.**

Patient's Name	Medicare # (HICN)
Signature of the patient or of the authorized representative	Date