HOME HEALTH ADVANCE BENEFICIARY NOTICE

We, _____, your home health agency, expect Medicare probably will not pay for: _____ _____, because: _____ _____ _____.

This is our opinion. Your doctor has ordered these services for you. We suggest you talk to your doctor, your family, and us about your need for these services. You can get these services if you think you need them. Unless you have other insurance, you may have to pay for these services yourself. We estimate all of these services will cost about $_____. You can telephone us at: (____)_____. TTY/TDD: (____)_____. Your "other insurance" is:_____.

IMPORTANT: Ask us to explain the services you may receive under each of your options below.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

☐ **Option A. YES.** I want to receive these home health services and get an official Medicare decision about coverage. Please submit a claim, with any evidence supporting my need for these services, to Medicare for its official decision and bill my other insurance, if any. I might have to pay for these services while Medicare is making its decision. If Medicare or another insurer does decide to pay and I have made any payments, I will be refunded any amounts that I am due. I agree to be fully and personally responsible for payment of any amount for which Medicare and my other insurance will not pay.

I understand that I can appeal if Medicare decides not to pay. Medicare will send me notice of its official decision not to pay that explains its decision in my case. That notice will explain how I can appeal Medicare's decision not to pay. If I do not hear from Medicare about its official coverage decision within 90 days, I can telephone Medicare at: (_____)_____. TTY/TDD: (_____)_____.

Option B. YES. I want to receive these home health services. Do NOT submit a claim to Medicare. I agree to be fully and personally responsible for payment of any amount for which my other insurance will not pay. I realize I cannot appeal to Medicare.

Check one box.

Option B.1. ☐ Please submit a claim to my other insurance, but not to Medicare.

Option B.2. ☐ Do not submit a claim either to Medicare or to my other insurance.

☐ **Option C. NO.** I have decided not to receive these home health services for which you expect that Medicare will not pay. I realize I cannot appeal your opinion that Medicare won't pay.

_____ _____

Date Signature of the patient or person acting on the patient's behalf

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

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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