ABN Information

What is an ABN form?

An ABN (Advance Beneficiary Notice of Non-coverage) form is used to notify patients that Medicare is unlikely to cover all or a portion of the requested supplies and/or services. Completion of the form by the patient serves as confirmation that the patient has received and understood the information contained on the form.

Instructions to complete the ABN form:

1) Write your name in on line “B”.
2) Write your patient Id (available from customer service) on line “C”.
3) Fill in the quantity information in box “D” according to your doctor’s prescription. If you are unsure what quantity your doctor has prescribed, customer service can look at your prescription and tell you.
4) Read the options in box “G”. You must choose one of the options and mark the box next to your preferred option.
5) Sign box “I”.
6) Date box “J”.
7) Complete the credit card authorization form on the last page.

A. Notifier: Specialty Medical Equipment, Inc. - 52040 Van Dyke Ave Shelby Twp, MI 48316 - (877) 622-3023

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** diabetic supplies 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.** diabetic supplies below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Diabetic testing meter, testing strips (qty: ____), and lancets (qty: ____) every 90 days for length of RX on file.	Meters are only covered once every 5 years. Based on LCD33822, your prescribed testing frequency is considered high utilization and Medicare may determine your physician's documentation does not support a covered need for the prescribed quantity of supplies.	$80.46/meter $8.32/box strips $1.42/box lancets

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.** diabetic supplies 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.

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

☐ **OPTION 1.** I want the **D.** diabetic supplies 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.** diabetic supplies 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.** diabetic supplies listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

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:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Card Number: _____ CVV / Security Code: _____
Card Expiration Date (mm/yy):
Cardholder Name (as shown on card): _____
Card Billing Address: _____
Card Billing City: _____
Card Billing State: _____ Card Billing Zip: _____

I,_____, authorize Specialty Medical Equipment, Inc. to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date