AUSTIN REGIONAL CLINIC

What is an ABN?

An ABN, Advance Beneficiary Notice, is a written document notifying you...

- that Medicare will probably deny payment for a specific service or item.
- the reason the doctor expects Medicare to deny payment.
- that you will be financially responsible for payment if Medicare denies payment.

An ABN also gives you the opportunity to refuse to receive the service or item.

How does receiving an ABN help me?

Medicare may not pay for a particular item or service, but that does not mean that you should not receive it. There may be a good reason your doctor recommended it.

The ABN protects you from unexpected financial liability in cases where Medicare denies payment.

The ABN helps you make an informed decision about whether to obtain the service or item. It allows you to decide if you will pay for it or choose not to receive it.

The ABN allows you to have your claim reviewed by Medicare if you do receive the service or item. This gives you the right to appeal Medicare's decision not to pay.

For more information,
visit **AustinRegionalClinic.com**

If I receive an ABN, what are my options?

☐ **1: YES, I want the service listed.**
If you choose Option 1, you may be asked to pay now, but your claim will be sent to Medicare.

If Medicare denies payment, you will be responsible for payment. That means you will have to pay for the service or item yourself or by some other insurance coverage.

However, you can appeal to Medicare by following the directions on the Medicare Summary Notice. Please inform clinic personnel if you have secondary insurance.

☐ **2: YES, I want the service listed, but don't bill Medicare.**
If you choose Option 2, this means that you will be responsible for payment and cannot appeal to Medicare.

If you have secondary insurance that may cover the service, you should not select this option, instead select option 1.

☐ **3: NO, I do not want the service or item listed.**
If you choose Option 3, this means you will not receive the service or item and you will not be responsible for payment.

You cannot appeal to see if Medicare will pay. If you decide not to receive something your doctor ordered for you, your doctor will be notified that you did not get the ordered test.

What are "frequency limited" services?

Certain services are covered by Medicare on a "frequency limited" basis. This means they are limited as to how often the service will be covered by Medicare. For example, a screening colonoscopy is covered once every 10 years. "Frequency limited" tests include lipids tests, PSA, PAP smears and occult blood.

You should always be asked to sign an ABN when receiving these services.

What is NOT covered by Part B Medicare?

Items and services that Medicare does not cover include, but are not limited to, the following:

- cosmetic surgery
- routine foot care: cutting corns or calluses (with few exceptions)
- hearing aids and exams for the purpose of fitting a hearing aid
- hearing tests that haven't been ordered by your doctor
- screening laboratory tests (with some exceptions)
- orthopedic shoes
- routine or yearly physical exams
  Medicare will cover a one-time Welcome to Medicare exam during the first year of enrollment and an Annual Wellness visit yearly thereafter. For more information on Annual Wellness visits, go to AustinRegionalClinic.com and search ***Medicare Wellness.***
- vaccines to prevent illness, such as shingles and tetanus vaccines

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