

Notifier:
6859 S.W. 18TH STREET, SUITE 200
BOCA RATON, FL 33433-7056

WOMEN'S HEALTH PARTNERS, LLC

DIPLOMATES OF THE AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY
(561)368-3775
www.myobgynoffice.com

7545 W. BOYNTON BEACH BLVD., SUITE 101
BOYNTON BEACH, FL 33437-6166

Patient Name:

Patient Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ 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. _____ below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|--|
| <input type="checkbox"/> OFFICE VISIT / PROCEDURE <input type="checkbox"/> BONE DENSITY <input type="checkbox"/> ULTRASOUND | Medicare allows coverage for services & items deemed medically reasonable & necessary according to Medicare rules. Medicare allows a screening PAP test and screening pelvic exam once every 2 years. Medicare may not pay for a service for your condition or may deny a service as too frequent. | <input type="checkbox"/> \$80.00 <input type="checkbox"/> \$80.00 <input type="checkbox"/> \$80.00 |

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. _____ 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. _____ 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. _____ 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. _____ 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: |
|----------------------|-----------------|

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