Spectrum Internal Medicine

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Advance Beneficiary Notice

Patient's Name:_____ DOB:_____ Date:_____

We expect Medicare will not pay for the service(s) that are described below, Medicare does not pay for all your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a service, does not mean that you should not receive it. There may be a good reason your doctor recommend it.

Right now, in your case, Medicare will probably not pay for the following:

- Physical Exam $182.00	**- Skin Tag Removal**	
- EKG $45	**- Other Services_____**	

Reason Medicare May Not Pay: (1) Routine Service Not Covered. (2) Medicare does not pay for these services as often as this - Denied as too frequent

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you may have to pay for them yourself. Before you make this decision about your options, you should read this entire notice carefully.
_Ask us to explain, if you do not understand why Medicare will not pay.
_Ask us how much this service will cost you. (Estimated cost $_____) in case you have to pay for them yourself. Please Choose One Option and Check The Box. Then Sign and Date

☐ **Option 1 YES, I want to receive these services.**

I understand that Medicare will not make decision to pay unless I receive these services. Please submit my claim to Medicare. I understand that you may bill me for the services and that I may have to pay the bill while Medicare is making a decision. If Medicare does pay, you will refund to me any payments I have made to you that are due to me. If Medicare denies payment, 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. I understand that I can appeal Medicare's decision.

☐ **Option 2 YES, I have decided to receive these services but Do not bill Medicare. I will be responsible for the full payment. I cannot appeal if Medicare is not billed.**

☐ **Option 3, I will not receive these services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.**

Date_____ Patient Signature_____