

**GARFIELD COUNTY HOSPITAL DISTRICT
ADVANCED BENEFICIARY NOTICE (ABN)**

NOTE TO PATIENT: You must make a choice receiving these laboratory tests.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of 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 particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended the test. Right now in your case, **Medicare probably will not pay for one or more of the laboratory test (s) indicated below for the following reasons:**

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests to be completed this often (frequency)	Medicare does not pay for experimental or research tests

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, **you should read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these laboratory tests will cost you (estimated cost: \$ _____), in case you have to pay for them yourself or through other insurance.

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

<input type="checkbox"/> OPTION #1: YES I want to receive these laboratory tests. I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare makes its decision. If Medicare does pay, GCHD will refund to me any payments I made to you that is 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 I can appeal Medicare's decision.
<input type="checkbox"/> OPTION #2: NO I have decided not to receive these laboratory tests. I will not receive these laboratory tests. 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. I will notify my doctor who ordered these laboratory tests that I did not receive them.

Print patient name

Medicare number

Signature of patient or responsible party

Date

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

GCHD STAFF:

- You **may not** sign this form on behalf of the patient/resident.
- If the patient/resident refuses to sign this form it is the GCHD policy to document the specifics of the patient refusal to sign the ABN. The GCHD representative signs the back of the ABN document as a witness to the patient/resident refusal to sign.