Instructions:
Advance Beneficiary Notice of Noncoverage (ABN)

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When to Provide the ABN

The ABN must be issued when an item or service is expected to be denied. This may occur at any one of three points during a course of treatment which are initiation, reduction, and termination, also known as “triggering events.”

Initiation:
An initiation is the start of a plan of care, or beginning of treatment. If a notifier believes that certain otherwise covered items or services will be noncovered (eg not reasonable and necessary) at initiation, an ABN must be issued prior to the beneficiary receiving the non-covered care.

Reduction:
A reduction occurs when there is a decrease in a component of care (ie frequency, duration). The ABN is not issued every time an item or service is reduced. But, if a reduction occurs and the beneficiary wants to receive care that is no longer considered medically reasonable and necessary, the ABN must be issued prior to delivery of this noncovered care.

Termination:
A termination is the discontinuation of certain items or services. The ABN is only issued at termination if the beneficiary wants to continue receiving care that is no longer medically reasonable and necessary.

When is ABN NOT Required?
The ABN is not required when the client is not admitted by the home health agency.
Sample ABN Form

Advance Beneficiary Notice of Noncoverage (ABN)

A. Notifier:  
B. Patient Name:  
C. Identification Number:  

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay:</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

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 does’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.

<table>
<thead>
<tr>
<th>I. Signature:</th>
<th>J. Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
### Guidelines for Completing ABN Form

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Notifier</strong></td>
<td>Name, address, and telephone number of BAYADA office issuing this notice. If necessary, include TTY number. This can be preprinted on the form. <em>(may be preprinted on form)</em></td>
</tr>
<tr>
<td><strong>B. Patient Name</strong></td>
<td>Insert the client’s full name as it appears on the Medicare card.</td>
</tr>
<tr>
<td><strong>C. Identification Number</strong></td>
<td>This field is optional. Medical record number may be inserted. <strong>Do not use</strong> the client’s Medicare number or Social Security number.</td>
</tr>
</tbody>
</table>
| **D. Item or Services expected to be denied** | Any of the following can be used in this section:  
- Item  
- Service  
- Supplies |
| **E. Reason Medicare May Not Pay** | Explain why the items, services, or supplies may not be covered by Medicare. Use language a lay person can understand.  
In order to be considered valid, there must be one reason for each item listed in Section D. The same reason for Medicare non-coverage may be applied to multiple items. |
| **F. Estimated Cost** | Notifies must make a good faith effort to provide a reasonable estimate of the actual cost. Estimate must be within $100.00 of the actual cost.  
For a service that costs $250.00, we can estimate between $150 – 300. |
| **G. Options** | Check one box. |

#### Option 1:

Beneficiary wants to receive the items, services or supplies and the notifier is required to submit a bill to Medicare.  
This box should be chosen for:  
- All dually eligible clients. For example, clients for whom we will be billing Medicaid.  
- Beneficiaries that need an official Medicare decision in order to file a claim with a secondary insurance.  

#### Option 2:

The beneficiary wants to receive items, services or supplies and agrees to pay out of pocket. No claim will be filed with Medicare and there are no
appeal rights associated with this option. This box should be chosen for:

- Clients who want to receive and pay for items, services, or supplies

**Option 3:**

The beneficiary does not want the items, services or supplies in question. There are no appeal rights associated with this option.

<table>
<thead>
<tr>
<th>H. Additional Information</th>
<th>This field is optional. This space may be used to provide additional clarification if needed. If a client is dually eligible we can write in this section that “Your Medical Assistance Plan will pay for this care”</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Signature</td>
<td>The form must be signed by the beneficiary or their representative. It should be noted on the form if:</td>
</tr>
</tbody>
</table>
|                           |  - representative signs the form  
|                           |  - client refuses to sign the form  |
| J. Date                   | The beneficiary or representative enters the date the form was signed. If they are physically unable to, the home health agency staff may insert the date. |

**Guidelines for Delivering ABN Form**

When delivering ABNs, we are required to explain the entire notice and its content and answer all questions before it is signed. The ABN must be delivered enough in advance of the services that the beneficiary or representative has time to consider the options and make an informed choice.

Employees or subcontractors of the notifier may deliver the ABN.

ABNs are never required in an emergency or urgent care situation.

BAYADA keeps the original of the completed and signed ABN. The beneficiary or representative receives a copy.