

Harvey Schonwald, M.D., F.A.C.S.

BOARD CERTIFIED, UROLOGIC SURGERY
ADULT & PEDIATRIC UROLOGY

Phone: 352-666-4766

10441 Quality Drive
Suite 205
Spring Hill, Florida 34609

Fax: 352-666-4366

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)—MEDICARE

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

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.
<input type="checkbox"/> 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. <input type="checkbox"/> 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. <input type="checkbox"/> 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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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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ADVANCE BENEFICIARY NOTICE (ABN)

DATE: _____ PATIENT: _____ COMMERCIAL INSURANCE: _____

- You are receiving this notice because your insurance company may not pay for all of the services that you receive during your visit to our office.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask questions.

Supplies and Services	Reason Insurance May not Pay	Estimated Cost

_____ YES I want to receive these services. If my commercial insurance carrier denies payment, I am completely responsible for payment in full. I understand that I can appeal this decision for nonpayment by my insurance carrier.

_____ NO I have decided not to receive these services.

_____ OTHER Should I decide to request these services in the future, I understand I will be charged and am responsible for payment in full.

By signing this notice you agree to take financial responsibility for the cost of the supplies and services listed above should your insurance company deny coverage for the listed items.

Guarantor Signature	Date:
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