SANFORD
Laboratories

Patient name:_____ *Notifier name*:_____
Identification Number: *(optional)*_____ *Notifier address*:_____
Notifier phone (including TTY):_____

Advance Beneficiary Notice of Non-coverage (ABN)

Medicare doesn't pay for everything, even some care you or your health care provider think you need. **We expect Medicare may not pay for the item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

Item, test, service or care			
Reason Medicare may not pay	Medicare does not pay for these tests for your condition.	Medicare does not pay for these tests as often as ordered for you.	Medicare does not pay for experimental or research use tests.
Estimated cost			

What to do now

- Read this notice to make an informed decision about your care.
- Ask any questions you have.
- Choose one option below to let us know if you still want to get the item, test, service or care.

Choose ONE option below. We can't choose for you.
If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

○ **Option 1: I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN).** You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.

○ **Option 2: I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.

○ **Option 3: I don't want the item, test, service or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay.

Additional Information:

This notice gives our opinion, not an official Medicare decision. For other questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Signing below means you received and understand this notice. You can ask to get a copy.

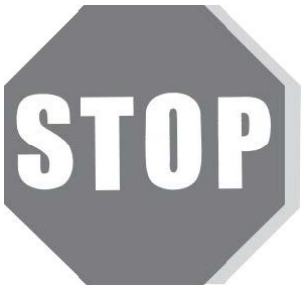
Signature	**Date** (mm/dd/yyyy)

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

PRA Disclosure Statement: 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. This information collection is for providers, suppliers, Hospice and Religious Non-medical HealthCare Institutes and Home Health Agencies to notify original Medicare beneficiaries of their potential financial liability under specific conditions. The time required to complete this information collection is estimated to average less than 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1879 of the Social Security Act, 42 CFR 411.404(b) and (c) and 411.408(d)(2) and (f). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Tests with Limited Coverage Policies (NCDs and LCDs)

To obtain this information, refer to Sanford Laboratories website at www.sanfordhealth.org/medical-services/laboratories



Did You Follow All the Steps For ABN Completion?

1. Print the **patient's name** where indicated at the top of the ABN.
2. In the **"Item, test, service or care"** section: Print the **name of the test(s) that may be denied** in the column with corresponding **"Reason Medicare may not pay**."
   If different reasons apply to some *OR* all of the tests, use the corresponding column for each test or please fill out an additional ABN for each reason.
   - In the **"Estimated Cost"** section: You **MUST** enter an **estimated cost of the test(s)** according to the appropriate Patient Fee Test Schedule.
3. **Obtain a check mark** or **"X"** from the beneficiary for **Option 1** *OR* **Option 2** *OR* **Option 3**. The beneficiary **can only choose one** of the three options. You cannot do this for them.
4. **Obtain beneficiary's or authorized representative's signature**.
5. **Date the form**.
6. Give the **yellow copy** of the ABN **to the patient**, and attach the **white copy** to the **test requisition**.

If any one of these steps is not complete, the ABN is not valid.