

Patient Name: _____ Identifier Number: _____

ADVANCED BENEFICIARY NOTICE OF NOTICE (ABN)

NOTE: If Medicare doesn't pay for (D) Chiropractic Manipulative Treatment, 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) Chiropractic Manipulative Treatment below.

(D) Chiropractic Manipulative Treatment (E) Reason Medicare May Not Pay (F) Estimated Cost

_____ 98940	_____ Not Medically Necessary	_____
_____ 98941	_____ Maintenance Care	
_____ 98942		

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) Chiropractic Manipulative Treatment listed above.
 - o 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.**

_____ **OPTION 1.** I want the (D) Chiropractic Manipulative Treatment 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 copays or deductibles.

_____ **OPTION 2.** I want the (D) Chiropractic Manipulative Treatment above but do not bill Medicare. You may be asked 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) Chiropractic Manipulative Treatment 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)

(I) Signature

(J) Date

PRINTED NAME: _____

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.

Aery Chiropractic & Acupuncture

Mail: PO Box 2611

Phone: (828) 526-1022

Fax: (828) 526-8493

In an effort to make the Medicare policy more understandable, please know that Medicare only pays for 80% of Spinal Manipulation. Period. This means that if you have a problem with your knee, foot, hip, hand, finger, shoulder, elbow or jaw, etc, Medicare will NOT pay for treatment in these areas.

MEDICARE WILL NOT PAY FOR ANY OF THE FOLLOWING UNDER ANY CIRCUMSTANCES:

- Examination
- X-Rays and interpretation
- Ice/Heat
- Electrical Muscle Stimulation
- Graston Technique
- Interferential
- Trigger Point Therapy
- Acupuncture
- Orthotics
- Nutritional Supplements
- Braces or supports
- Rehabilitation Exercises
- Extremity Manipulation
- Monthly Maintenance Manipulation
- All lab work
- Other therapies

Every January, Medicare gives us a new limiting charge that we are allowed to charge you. They will possibly reimburse you 80% of that amount and not a penny more depending on whether or not they determine that treatment is "reasonable and necessary." Our Non-Medicare charge for spinal manipulation is usually \$55.00

I acknowledge that I have read and understand the above information.

Please sign that you have read about Medicare Fees.

Signature

✕

Printed Name
