A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

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.

☐ **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.

☐ **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.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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.

Jefferson ValleyPharmacy

BENEFICIARY INFORMATION (please print)

Last Name First Name Middle Initial

Date of Birth Social Security Number

Sex ☐Male ☐Female Marital Status ☐Married ☐Single ☐Divorced ☐Widowed

Address

City State Zip

Place of Residence (i.e. Beneficiary Home, Caregiver, LTC, SNF, w/Family

Emergency Contact Person Emergency Contact's Phone Number

Caregiver's Name Caregiver's Phone Number

PHYSICIAN INFORMATION

Physician's Name

Office Address

City State Zip

Office Phone Number Date of Last Office Visit

INSURANCE INFORMATION

Medicare Number Part B Effective Date

Name of Secondary Insurance Phone Number

Policy or ID Number Group Number

Name of Policyholder (if other than Beneficiary)

☐Self ☐Spouse ☐Child

Beneficiary Relationship to Policyholder

Policyholder Date of Birth Policyholder Social Security Number

Employer's Name

Employer's Address

City State Zip

I understand that this information is vital for processing Beneficiary prescriptions and will remain confidential.

Beneficiary or Caregiver's Signature Date

Beneficiary or Caregiver's Printed Name

JEFFERSON VALLEY PHARMACY

ASSIGNMENT OF BENEFITS

Beneficiary Name *(Printed)* _____

Address _____

Phone Number _____ DOB _____

I assign the right and responsibility to JEFFERSON VALLEY PHARMACY to bill on my behalf, and accept payment for Medicare DMEPOS products and services provided to me, the Beneficiary.

I understand that I am responsible to pay any deductible amount applied to the claims and the coinsurance, which is 20 percent of the allowable or approved charge for a product or service.

I permit JEFFERSON VALLEY PHARMACY to release and collect my health information, and other information, as required (and as permitted by the HIPAA Regulations) from my health care providers and Medicare to receive payment from Medicare.

I understand that this form will be maintained and made available to Medicare or its representatives.

_____ _____

Beneficiary/Caregiver Signature Date

_____

Caregiver Printed Name (If Applicable)