CONNELLEY FAMILY MEDICAL PLLC
777 JORDAN DRIVE
MONTICELLO, AR 71655
ADVANCED BENEFICIARY NOTICE
(ABN) NON-MEDICARE

PATIENT NAME:_____ DOB:_____

We will file claim(s) as courtesy per billing regulations, however whether insurance pays or not the bill is your responsibility. In part, it is your responsibility as a patient to provide us with accurate and up to date insurance information so we can bill accordingly. Your insurance is a contract between you and your insurance company, and we are not part of the contract. Please be aware that some, or perhaps all, of the services provided may be non-covered services or not considered reasonable and necessary under your insurance policy, or even some care that you and/or your health care provider discuss.

- **Item or Service: Office visits, Labs, X-rays, Injections, Procedures**
- **Because: Services are non-covered**

The purpose of this form is to help you make an informed decision about weather or not you want to receive items/services that are provided/recommended, knowing that there is a possibility you may be responsible for them yourself. Please read the entire notice carefully before making a decision. Please ask questions.

☐ Option 1: Yes, I want to receive the services listed above. You may ask to be paid now, but I also want my insurance filed for an official decision on payment, which is sent to me on an explanation of benefits (EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance by following the directions included in my policy. If my insurance does pay, it's the clinic/billing companies responsibility to refund any payments, except co-pays or deductibles.

☐ Option 2: Yes, I want to receive these services listed above, but do not bill my insurance company. You may ask to be paid now as I am responsible for payment. I cannot appeal if my insurance is not billed.

☐ Option 3: No, I have decided not to receive these services listed above. I understand that with this decision I am not responsible for payment and I cannot appeal to see if my insurance would pay.

_____ _____
Signature of patient/person acting on patient's behalf Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If we submit a claim to your insurance claim please be aware that we will share your health information with the insurance company regarding your claim. Both the clinic and the insurance company abide by HIPPA.

ARKANSAS MEDICAID WAIVER

CONNELLEY
Family Medical PLLC

PHYSICIAN NOTICE:

Patient Name:_____
Patient DOB:_____
Date of Service:_____

Your Medicaid will not cover services that it determines has exceeded your annual benefit limits. Medicaid allows 12 physicians visits and a max of $500 lab/x-ray services per state fiscal year. Medicaid has certain categories that do not pay our office. Some Medicaid categories require a PCP be selected.

I believe that, in your case, Medicaid may deny payment for (service):

_____

_____

for the following reasons (12 visit limit; $500 lab/x-ray exceeded; PCP; Category):

_____

_____

The charge for this service will be:_____

_____

_____

MEMBER AGREEMENT:

"I have been pre-notified by my physician that he or she believes that, in my case, Medicaid is likely to deny payment for the services identified above, for the reasons stated. If my Medicaid denies payment for exceeding my annual benefit limit, for PCP issues, or because I have a category that does not pay, I agree that I shall be personally and fully responsible for payment for all such services including any follow-up services that may be required to complete the treatment or to repair any damage or address any complication of the treatment. I understand that I am required to sign a new waiver for every visit after one of the above conditions have been met until the new state fiscal year begins and my benefits are restored."

_____ Date: _____

Member's signature

_____ Date: _____

Witness' Signature

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (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
OFFICE VISIT LABORATORY SERVICES XRAYS ULTRASOUNDS INJECTIONS PROCEDURES	NON-COVERED OR 20% THAT MEDICARE DOES NOT COVER	$140 NEW PATIENT $100 ESTABLISHED ADDITIONAL CHARGES WILL BE BASED ON TESTING PERFORMED AND OUR FEE SCHEDULE

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:

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