

Form Instructions
Advance Beneficiary Notice of Non-coverage (ABN)
OMB Approval Number: 0938-0566

When Medicare is not likely to cover a specific item or service, health care providers and suppliers must use this ABN to let the patient know they may be financially liable before they get the items or services. “Notifiers” required to use this notice include:

- Physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Medicare Part B (including independent laboratories);
- Hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Medicare Part A;
- Home health agencies (HHAs) providing care under Medicare Part A or Part B; and
- Medicare inpatient hospitals and skilled nursing facilities (SNFs) must use the ABN for Medicare Part B items and services (although they use other approved notices for Medicare Part A items and services).

Requirements for Notifiers

Notifiers must:

- Deliver the ABN to the patient or their representative before providing the items or services;
- Review the ABN with the patient or their representative and answer any questions before it’s signed;
- Deliver the ABN far enough in advance that the patient or representative has time to consider the options and make an informed choice;
- Give a copy to the patient or representative, if requested, once all blanks are completed and the form is signed; and
- Retain a copy of the completed, signed ABN on file.

Notifiers can use employees or subcontractors to deliver the ABN. ABNs are never required in emergency situations.

The ABN may also be used to notify patients of their financial liability for items or services that Medicare never covers. When the ABN is used this way, the patient doesn’t need to choose an option box or sign the notice.

ABN Changes

The ABN is a formal information collection subject to approval by the Executive Office of

Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and re-approval every 3 years. With the latest PRA submission, changes have been made for plain language, improved usability and reduced burden for notifiers.

How to Complete the ABN

Download the ABNs from the CMS website:

[CMS.gov/Medicare/Medicare-General-Information/BNI/ABN.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html).

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed to complete the Medicare Exclusions & Cost Table when a legal-size page is used.

- **Patient name:** Enter the first and last name of the patient receiving the notice, along with a middle initial if there's one on the patient's Medicare card. The ABN will not be invalidated by a misspelling or missing initial, as long as the patient or representative recognizes the name listed on the notice as that of the patient.
- **Identification number:** This is optional. Notifiers may enter a patient identification number or internal filing number (like a medical record number) that helps link the notice with a related claim. The absence of an identification number does not invalidate the ABN. Medicare beneficiary identifiers (MBIs), or Social Security numbers should not appear on the notice.
- Notifiers must place their name, address, and phone number (including TTY number when needed) at the top right of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, handwriting, pre-printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the header as long as it's specified in the Additional Information section who should be contacted for billing questions.

CMS will work with our contractors to ensure consistency when determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe a contractor inappropriately invalidated an ABN.

Medicare Exclusions & Cost Table Entries

- Entries in the Medicare exclusions & cost table may be typed or handwritten but should be large enough (e.g. 12-point font) to read easily. 10 point font can be used when detailed information won't fit in the allowed space.
- Under the **"Item, test, service or care"** header, list the specific names of the items or services believed to be non-covered.
- In the case of partial denials, list the excess component(s) of the item, or service expected to be denied.

- For repetitive or continuous non-covered care, specify the frequency and/or duration of the item or service.
- General descriptions of specifically grouped supplies are permitted. For example, “wound care supplies” would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.
- When a reduction in services occurs, notifiers must provide enough additional information, so the patient understands what’s being reduced. For example, entering “wound care supplies decreased from weekly to monthly” would be appropriate to describe a decrease in frequency for this category of supplies; just writing “wound care supplies decreased” is insufficient.
- Under the “**Reason Medicare may not pay**” header, explain in plain language why the listed items, tests, services or care may not be covered by Medicare. Three commonly used reasons for non-coverage are:

“Medicare does not pay for this test for your condition.”

“Medicare does not pay for this test as often as this (denied as too frequent).”

“Medicare does not pay for experimental or research use tests.”

For the ABN to be valid, there must be at least one reason applicable to each item or service listed in the “**Item, test, service or care**” column. The same reason for non-coverage may be applied to multiple items when appropriate.

- Under the “**Estimated cost**” header, ensure the patient has all available information to make an informed decision about whether or not to get services that may not be covered by Medicare. Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under the “Item, test, service or care” column. However, an estimate that substantially exceeds the actual cost would generally still be acceptable, since the patient wouldn’t be harmed if actual costs were less.

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in the “**Item, test, service or care**” column and include a cost estimate for each item or service. If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing) and costs can’t reasonably be estimated when the ABN is delivered, the notifier may enter the initial cost estimate and indicate the possibility of further testing. If for some reason the notifier can’t estimate projected costs when the ABN is delivered, the notifier may indicate in the cost estimate area that no cost estimate is available. We don’t expect either of these last two scenarios to be routine, but the patient would have the option of signing the ABN and accepting liability in these situations.

Options Box

The patient or their representative must check one of the boxes in the Options Box section.

- **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.

This option allows the patient to get the items and/or services and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed. Suppliers and providers who don't accept Medicare assignment may make modifications to Option 1 only as specified below under “**Additional Information.**”

Special guidance for people dually enrolled in both Medicare and Medicaid (has a Qualified Medicare Beneficiary (QMB) Program and/or Medicaid coverage) ONLY:

Dually eligible patients must be instructed to check **Option Box 1** on the ABN for a claim to be submitted for Medicare adjudication. Strike through **Option Box 1** as shown below:

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.

The provider can't bill the dual eligible beneficiary when the ABN is delivered. Providers must not bill the patient until adjudication by both Medicare and Medicaid because of federal laws that affect coverage and billing for dual eligible patients. If Medicare denies a claim where an ABN was needed to transfer financial liability to the patient, the claim may be crossed over to Medicaid or submitted by the provider for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue a Remittance Advice based on this determination.

Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the patient in these circumstances per Medicare policy:

- If the patient has QMB coverage without full Medicaid coverage.
- If the patient has full Medicaid coverage and Medicaid denies the claim (or won't pay because the provider doesn't participate in Medicaid), subject to any state laws that limit patient liability.

Note: These instructions should only be used when the ABN is used to transfer potential financial liability to the patient, not in voluntary instances.

- **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 I can't appeal, since Medicare isn't billed.

This option allows the patient to get the non-covered items and/or services and pay for them

out of pocket. No claim will be filed, and Medicare won't be billed, so there are no appeal rights.

- **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.

This option means the patient doesn't want the item or services. By checking this box, the patient understands that the items or services won't be provided, so there are no appeal rights. The patient or their representative must choose only one of the 3 options in the options box.

Unless otherwise instructed according to these instructions, the notifier must not decide for the patient which of the 3 options to select. Pre-selection of an option by the notifier invalidates the notice. If the patient asks, notifiers may enter the patient's selection if he or she is physically unable to do so. In these cases, notifiers must annotate the notice to indicate this happened.

If there are multiple items or services listed in the service table and the patient wants some, but not all, of the items or services, the notifier can use more than one ABN. Use an additional ABN to list the items/services the patient wants to receive with the corresponding option.

If the patient can't or won't make a choice, the notice should be annotated "patient refused to choose an option."

Additional Information

Notifiers may use this space to provide additional clarification they believe will be useful to patients. For example, notifiers may use this space to include:

- A statement advising the patient to notify their provider about certain tests that were ordered, but not received
- Information on other insurance coverage, such as a Medigap policy (if applicable)
- An additional dated witness signature
- Other necessary annotations. Annotations will be assumed to have been made on the same date as the date in the signature line. If annotations are made on different dates, those dates should be part of the annotations.

***Special guidance for non-participating suppliers and providers (those who don't accept Medicare assignment) ONLY:**

Strike the last sentence in the Option 1 paragraph with a single line so that it appears like this: ~~If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.~~

This single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished. Alternatively, the line can be handwritten on an already printed ABN. The sentence should be stricken and can't be entirely concealed or deleted. There is no CMS requirement for suppliers or the patient to place initials next to the stricken sentence or date the

annotations when the notifier makes the changes to the ABN before issuing the notice to the patient.

When this sentence is stricken, the supplier should include the following CMS- approved unassigned claim statement in the “**Additional Information**” section:

“This supplier doesn’t accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I’m responsible for paying the supplier’s charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier’s charge.”

This statement can be included on ABNs printed for unassigned items and services, or it can be handwritten in a legible 10 point or larger font.

An ABN with the Option 1 sentence stricken must contain the CMS-approved unassigned claim statement as written above to be considered valid notice. Similarly, when the unassigned claim statement is included in the “Additional information” section, the last sentence in Option 1 should be stricken.

Signature Line

Once the patient reviews and understands the information contained in the ABN, the patient (or representative) must sign and date the signature line. This line can’t be completed in advance of the rest of the notice.

- **Signature:** The patient (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. Form signature should be in cursive, with printed annotation if needed to be understood. If a representative signs on behalf of a patient, he or she should write out “representative” in parentheses after his or her signature. The representative’s name should be clearly legible or noted in print.
- **Date:** The patient (or representative) must write the date he or she signed the ABN. If the patient has physical difficulty writing and asks for assistance completing this blank, the date may be inserted by the notifier.

Disclosure Statement

The disclosure statement is required to be included on the notice. The disclosure statement may be printed on a separate page, or the notice may be printed as a double-sided document.