

A. Notifier: NORTHSTAR EMS, INC. (ONE WITH PAPERWORK AND MUST GIVE COPY TO PATIENT)

B. Patient Name: \_\_\_\_\_

C. Incident 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
AMBULANCE AND MILEAGE (Ambulance Transport)  YOUR QUOTED PRICE IS: \$ _____	TRANSPORT THAT IS NOT EITHER REASONABLE OR NECESSARY OR THAT IS NOT TO THE CLOSEST APPROPRIATE FACILITY THAT CAN MEET THE PATIENT'S NEEDS IS NOT PAYABLE BY MEDICARE.	BETWEEN \$400 AND \$5000 DOLLARS DEPENDING OF TYPE OF SERVICE AND NUMBER OF MILES.

### 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.

<input type="checkbox"/> <b>OPTION 1.</b> I want the <b>D</b> 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 <b>can appeal to Medicare</b> 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.
<input type="checkbox"/> <b>OPTION 2.</b> I want the <b>D</b> listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I <b>cannot appeal if Medicare is not billed.</b>
<input type="checkbox"/> <b>OPTION 3.</b> I don't want the <b>D</b> listed above. I understand with this choice I am <b>not</b> responsible for payment, and I <b>cannot appeal to see if Medicare would pay.</b>

**H. Additional Information:** In some cases, base rate and mileage may be covered to the closest appropriate facility if the origin and destination are a Medicare covered service. Contacting our office and discussing your transport may be beneficial for you. Contact us at 205-247-4740 or 888-828-0911 during business hours or our dispatch center at 205-345-0911 after normal business hours. We will be glad to discuss and evaluate your transportation needs.

**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:
---------------	----------

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.