SKILLED NURSING FACILITY'S NAME & ADDRESS
TELEPHONE NO. AND TTYTDD NO.

Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)

Date of Notice:_____

NOTE: You need to make a choice about receiving these health care items or services.

It is not Medicare's opinion, but our opinion, that Medicare will not pay for the item(s) or service(s) described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason to receive it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance you may have. Your other insurance is:_____
- If in 90 days you have not gotten a decision on your claim, contact the Medicare contractor at: Address:_____ _____ or at: Telephone: _____TTY/TDD:_____.
- If you receive these items or services, we will submit your claim for them to Medicare.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **DATE & SIGN** THIS NOTICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision.

☐ **Option 2. NO. I will not receive these items or services.** I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I understand that, in the case of any physician-ordered items or services, I should notify my doctor who ordered them that I did not receive them.

Patient's Name:_____ Medicare # (HICN):_____

_____ _____

Date **Signature of the patient or of the authorized representative**

Form No. CMS-10055