

Totem Lake Family Medicine  
11800 NE 128<sup>th</sup> St., Suite 560  
Kirkland, WA 98034-3084

Patient's Name \_\_\_\_\_

### Advance Beneficiary Notice (ABN)

We expect Medicare will not pay for the service(s) that are described below, Medicare does not pay for all 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 service, does not mean that you should not receive it. There may be a good reason your doctor recommended it.

**Right now, in you case, Medicare will probably not pay for:**

- |   |          |
|---|----------|
| <input type="checkbox"/> Physical Exam    | \$182.00 |
| <input type="checkbox"/> EKG              | \$ 41.00 |
| <input type="checkbox"/> Physical and Pap | \$182.00 |
| <input type="checkbox"/> Skin Tag Removal | \$       |
| <input type="checkbox"/> Other _____      | \$       |

Because:

- Routine Service Not covered  
 Medicare does not pay for these services as often as this. (Denied as too frequent)

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

- Ask us to explain, if you do not understand why Medicare will not pay.  
 Ask us how much these services will cost you. (Estimated Cost \$ \_\_\_\_\_) in case you have to pay for them yourself.

**Please Choose One Option and Check The Box. Then Sign and Date.**

**Option 1 YES, I want to receive these services.**

I understand that Medicare will not decide whether to pay unless I receive these services. Please submit my claim to Medicare. I understand that you may bill me for services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I have made to you that are due to me. 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 have decided not to receive these services.**

I will not receive these 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature