MSI PHYSICAL THERAPY
40 Main Street
Chatham, NJ 07928
(973) 635-2800

MSI PHYSICAL THERAPY
Bldg 339-2nd Floor
Newark, NJ 07114
(973) 643-8383 ext 217

MSI PHYSICAL THERAPY
870 Boulevard
Kenilworth, NJ 07033
(908) 245-5566

Patient's Name: Medicare # (HICN)/Other Ins. I.D. #

ADVANCED **B**ENEFICIARY **N**OTICE **(ABN)**

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

We expect that Medicare/your insurance will not pay for the item(s) or service(s) that are described below. Medicare/your insurance does not pay for all of your health care costs. Medicare/your insurance only pays for covered items and services when Medicare/your insurance rules are met. The fact that Medicare/your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare/your insurance probably will not pay for….**

Items of Service: Include but are not limited to the following: Services exceeding Medicare or other insurance maximum allowable benefits; Maintenance services, therapy supplies or services that exceed you benefit limit or are rendered during a period of ineligibility.

Because: Not a covered service or considered maintenance or non-therapeutic.

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/your insurance 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.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX**. SIGN AND DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance 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 I can appeal my insurance company's decision.

☐ **Option 2. NO**. **I have decided not to receive these items or services**. I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance won't pay.

_____ _____

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare/your insurance, your health information on this form may be shared with Medicare/your insurance. Your health information, which Medicare/your insurance sees, will be kept confidentially by Medicare/your insurance.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (May 2006)