



**Medical Imaging, P.A.**  
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**Independence**  
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**Advance Beneficiary Notice of Noncoverage (ABN)**

Patient Name: \_\_\_\_\_

Identification # \_\_\_\_\_

**NOTE:** If Medicare doesn't pay for \_\_\_\_\_, you may have to pay. Medicare does not pay everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for \_\_\_\_\_.

	<u>Estimated Cost:</u>
<input type="checkbox"/> <b>Screening Mammography</b> This exam is covered only once every thirteen- (13) months.	
<input type="checkbox"/> <b>Non-Invasive Vascular Testing – ex: Carotid, Renal, AAA...</b> The diagnosis of _____ is not listed in the Indications of Coverage and will be denied as not reasonable & necessary under Section 1862(a)(1)(A).	
<input type="checkbox"/> <b>CT Angiography/CTA</b> The diagnosis of _____ is not listed in the Indications of Coverage and will be denied as not reasonable & necessary under Section 1862(a)(1)(A).	
<input type="checkbox"/> <b>3D Interpretation &amp; Reporting of Imaging Studies – 3D Reconstruction</b> The diagnosis of _____ is not listed in the Indications of Coverage and will be denied as not reasonable & necessary under Section 1862(a)(1)(A).	
<input type="checkbox"/> <b>Bone Density Analysis</b> Medicare covers a bone mass measurement once every 2 years and only more frequently if the individual has documented deficiency or is on osteoporosis drug therapy.	
<input type="checkbox"/> <b>Magnetic Resonance Angiography/MRA</b> The diagnosis of _____ is not listed in the Indications of Coverage and will be denied as not reasonable & necessary under Section 1862(a)(1)(A).	
<input type="checkbox"/> <b>Magnetic Resonance Imaging/MRI Head (Brain)</b> The diagnosis of _____ is not listed in the Indication of Coverage and will be denied as not reasonable & necessary under Section 1862(a)(1)(A).	
<input type="checkbox"/> _____ The diagnosis of _____ is not listed in the Indication of Coverage and will be denied as not reasonable & necessary under Section 1862(a)(1)(A).	

**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 \_\_\_\_\_ 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.

Check only one box. We cannot choose a box for you

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

**Additional Information:**

**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.

**Signature:** \_\_\_\_\_ **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.