(A) Notifier(s): **COURY & BUEHLER PHYSICAL THERAPY**

(B) Patient Name: _____ **(C) Identification Number**: _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) *SEE BOX 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) *SEE BOX D* below.

(D)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
- Electrical Stimulation Pads - Iontophoresis Pads - Tape	Medicare also does not pay for certain clinical supplies used in physical therapy such as electrical stimulation pads. If electrical stimulation is indicated for your treatment, you are responsible for the purchase price of the electrical stimulation pads It is customary to pay for any supplies once you have received them. This is a onetime charge as the pads are reusable. For sanitary reasons, these pads are only used by you. We store them in our files under your name and dispose of them when you are discharged. Other less commonly used supplies that Medicare does not reimburse for include iontophoresis pads and tape. If your therapist or physician feels these items are necessary, we will explain the purpose and the cost of each item before the procedure is done. You will have the option of paying for and receiving the supplies or deciding not to use the supplies.	$ 12.00 + tax $ 18.00 + tax $ 3.00 - $ 6.00

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) *SEE BOX 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.

❑ **OPTION 1**. I want the (D) *SEE BOX D* 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.

❑ **OPTION 2**. I want the (D) *SEE BOX D* 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.

❑ **OPTION 3**. I don't want the (D) *SEE BOX D* listed above. I understand with this choice I am not responsible for payment for the (D) *SEE BOX D* listed above. Also understand with this choice, I cannot appeal to see if Medicare would pay.

(H) Additional Information: Medicare Part B pays for physical therapy as long as it is medically necessary, but only up to the annual benefit cap of $1980.00. Prior to reaching the benefit cap, you pay 20% of the Medicare-approved amount after you have met your annual deductible of $183.00. After you have reached the $1860.00 benefit cap, you will be responsible for 100% of the charge, unless you have a diagnosis that is an exception to annual benefit cap or other insurance coverage. Many physical therapy diagnoses are an exception to the annual Medicare benefit cap. Please consult with your therapist regarding exceptions to cap.

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. A copy should also be given to you for your records.

(I) Signature: _____ **(J) Date**: _____

(A) Notifier(s): **COURY & BUEHLER PHYSICAL THERAPY**

(B) Patient Name: _____ **(C) Identification Number**: _____

HOME HEALTH & HOSPICE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) *SEE BOX 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) *SEE BOX D* below.

(D)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
- Outpatient Physical Therapy Services	If a patient is under a home health or hospice plan of care under their Medicare Part A or Part B benefits, outpatient physical therapy will not be covered. It is the responsibility of the beneficiary to disclose any home health or hospice treatments being received and provide home health or hospice discharge documentation if home health or hospice services were provided within the past 3 months. If outpatient physical therapy services are denied coverage by Medicare due to home health or hospice services, you will be responsible for the treatments provided and not covered by your Medicare benefits.	97161-97163: 1 unit $85.32 97164: 1 unit $58.32 97112: 1-2 units $36.00- $63.77 97150: 1 unit $18.32 97140: 1 unit $32.27

WHAT YOU NEED TO DO NOW:
- **This ABN has been issued since the provider has reason to believe that the patient has been enrolled, or currently enrolled, in home health or hospice services.**
- 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) *SEE BOX 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.**

❑ **OPTION 1**. I want the (D) *SEE BOX D* 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.

❑ **OPTION 2**. I want the (D) *SEE BOX D* 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.

❑ **OPTION 3**. I don't want the (D) *SEE BOX D* listed above. I understand with this choice I am not responsible for payment for the (D) *SEE BOX D* listed above. Also understand with this choice, I cannot appeal to see if Medicare would pay.

(H) Additional Information: Medicare Part B pays for physical therapy as long as it is medically necessary, but only up to the annual benefit cap of $1980.00. Prior to reaching the benefit cap, you pay 20% of the Medicare-approved amount after you have met your annual deductible of $183.00. After you have reached the $1980.00 benefit cap, you will be responsible for 100% of the charge, unless you have a diagnosis that is an exception to annual benefit cap or other insurance coverage. Many physical therapy diagnoses are an exception to the annual Medicare benefit cap. Please consult with your therapist regarding exceptions to cap.

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. A copy should also be given to you for your records.

(I) Signature: _____ **(J) Date**: _____

Physical, Occupational, and Speech Therapy	
Coverage under Medicare	Medicare helps pay for medically necessary outpatient physical and occupational therapy and speech-language pathology services when: • Your doctor or therapist sets up the plan of treatment, and • Your doctor periodically reviews the plan to see how long you will get therapy. You can get outpatient services from a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or public health agency. Also, you can get services from a Medicare-approved physical or occupational therapist, in private practice while in his or her office or in your home. Medicare doesn't pay for services given by a speech pathologist in private practice. You can get these services from any Medicare-approved outpatient provider.
The amount you need to pay	Medicare is required to limit how much it pays for outpatient therapy services per year. This is called an annual financial limitation, or cap. Your Medicare benefit for outpatient physical therapy and speech-language pathology services (combined) is limited to $1980.00 per year. There is a separate yearly benefit limit of $1980.00 for outpatient occupational therapy. Medicare Part B pays for Occupational, Physical, and Speech therapy as long as it is medically necessary, but only up to the yearly benefit limit of $1980.00. Before the limits, you pay 20% of the Medicare-approved amount after you have met your yearly deductible. After you have reached the $1980.00 cap, you will be responsible for 100% of the charge, unless you have a diagnosis that is an exception to yearly cap or other insurance coverage. There is no cap if you go to a hospital outpatient therapy department. People who occupy a Medicare-certified bed in a skilled nursing facility are limited to the cap amounts and cannot receive additional covered outpatient hospital therapy while in the certified bed. For more information, you may call 1-800-MEDICARE (1-800-633-4227).
The part of Medicare that pays for this service or supply	Part **B** Benefit
Medicare Contact for additional information	State of California Carrier: 1-800-633-4227 1-800-MEDICARE
Important notes	1. You must pay an annual $183.00 (in 2017) deductible for Part B services and supplies before Medicare begins to pay its share. 2. Actual amounts you must pay may be higher if a doctor, health care provider, or supplier does not accept assignment.