SANFORD
Laboratories

Advance Beneficiary Notice of Non-coverage (ABN)

Facility Name:_____
Address:_____
_____
Phone:_____

A. Notifier:_____

B. Patient Name:_____

C. Identification Number:_____

DOB:_____

NOTE: If Medicare doesn't pay for lab test(s) 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 **lab test(s)** below.

Lab Test(s)	Reason Medicare May Not Pay:	Estimated Cost
	☐ Medicare does not pay for these tests for your condition ☐ Medicare does not pay for these tests as often as this (denied as too frequent) ☐ Medicare does not pay for experimental or research use tests	

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 **lab test(s)** 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.

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

☐ **OPTION 1.** I want the **lab test(s)** 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 **lab test(s)** 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 **lab test(s)** 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:

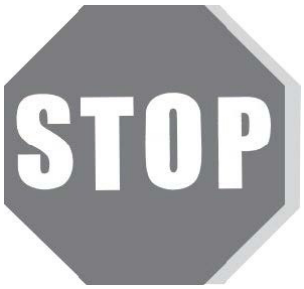
This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

Signature:	**Date:**

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

Tests with Limited Coverage Policies (NCDs and LCDs)

To obtain this information, refer to Sanford Laboratories website at www.sanfordhealth.org/medical-services/laboratories



Did You Follow All the Steps For ABN Completion?

1. Print the **patient's name** where indicated at the top of the ABN.
2. In the **"Lab Test(s)"** section: Print the **name of the test(s) that may be denied**.
   - In the **"Reason Why Medicare May Not Pay"** section: Indicate by checking the **appropriate reason**. ***If different reasons apply to some *OR* all of the tests, please indicate the test name next to the reason or please fill out an additional ABN for each reason.***
   - In the **"Estimated Cost"** section: You **MUST** enter an **estimated cost of the test(s)** according to the appropriate Patient Fee Test Schedule.
3. **Obtain a check mark** or **"X"** from the beneficiary for **Option 1** *OR* **Option 2** *OR* **Option 3**. The beneficiary **can only choose one** of the three options. You cannot do this for them.
4. **Obtain beneficiary's or authorized representative's signature**.
5. **Date the form**.
6. Give the **yellow copy** of the ABN **to the patient**, and attach the **white copy** to the **test requisition**.

If any one of these steps is not complete, the ABN is not valid.