County of Nelson c/o NELSON COUNTY EMS

1 Court Square 2nd Floor Bardstown, KY 40004 (502) 348-4929

A. Patient Name:_____ **C. Social Security Number:**_____

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **Ambulance Service** 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 **Ambulance Service** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
AMBULANCE SERVICE	☐ Does not pay for services to or from a physician's office. ☐ Does not pay for services to or from an outpatient clinic. ☐ Does not pay for services to or from a Long Term Facility or Residence to a Long Term Facility. ☐ Does not pay for services from a Long Term Facility to another Long Term Facility or Residence. ☐ Services may not be covered if not being transported to the closest appropriate facility. ☐ Does not pay for services from Long or Short Term Facilities to Residence, unless the patient is proven to be bedridden with specific diagnosis met within CMS guidelines. ☐ Other _____	$ 775.00 per BLSN Base Rate and $ 17.65 per each loaded mile $ _____

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 **Ambulance Service** 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 **Ambulance Service** 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 **Ambulance Service** 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 **Ambulance Service** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. 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 also receive a copy.

I. Signature:	J. Date:

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