**Skilled Nursing Facility:**

**Beneficiary's Name:** **Identification Number:**

## Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)

Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements.

**Beginning on**_____, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

| Care: | Reason Medicare May Not Pay: | Estimated Cost: |
|---|---|---|
| | | |

**WHAT TO DO NOW:**

- Read this notice to 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 get the care listed above.

**Note:** If you choose Option 1, we may help you use any other insurance that you may have, but Medicare can't require us to do this.

**OPTIONS: Check only one box. We can't choose a box for you.**

☐ **Option 1.** I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN.

☐ **Option 2.** I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. **I cannot appeal because Medicare won't be billed.**

☐ **Option 3.** I don't want the care listed above. I understand that I'm not responsible for paying, and **I can't appeal to see if Medicare would pay**.

**Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call **1-800-MEDICARE** (1-800-633-4227) /**TTY:** 1-877-486-2048. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

Signing below means that you've received and understand this notice. You'll also get a copy for your records.

| Signature of Patient or Authorized Representative* | Date |
|---|---|
| | |

* If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.