Kadence Healthcare, Inc.
10840 Walker St, Cypress CA 90630 / 8245 Ronson Rd Ste G, San Diego CA 90211 • (877)449-8900

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

A. Notifier:_____ **DOB:**_____

B. Patient Name:_____ **C. Identification #:** _____

NOTE: If Medicare, Medi-Cal, or other insurance [collectively "MY INSURANCE"] doesn't pay for items listed in **Section D** below, you may have to pay. Medicare or MY INSURANCE 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 or MY INSURANCE may not pay for the items listed in **Section D** below.

D. ITEMS & ESTIMATED COSTS

☐ E0147 Rollator Walker $300	☐ E0260/E0261 Hospital Bed $175-$400/mo	☐ E0600 Suction Pump $500
☐ E0143 FW Walker w/ Accessories $300	☐ E0185 Overlay Mattress $350	☐ A4628/A4624 Suction Sup. $350
☐ K0011 Motorized Wheelchair w/ Acc. $5000+	☐ E0277 Low-Airloss or AP Mattress $650/mo	☐ E0601 CPAP w/ Supplies $2500
☐ E2601/E2603Seat Cushion $280	☐ E1390 Oxygen Concentrator $250/mo	☐ E0470 BiPAP & Sup. $5800
☐ E0105 Cane Single-Point or Four-Pronged $75	☐ E0431 Oxygen Port. Tank System $50/mo	☐ E0471 BiPAP ST & Sup. $9000
☐ K0004 High-Strength Lt. Wt. Wheelchair $850	☐ E1392 Portable Oxygen System $1800/mo	☐ Trach Care Supplies $1000
☐ E2611 Back Cushion $335	☐ E0570 Nebulizer w/ Accessories $200	☐ Ventilator (E0463/E0464) $3450/MO
☐ E0600 Enteral Supplies $2000	☐ **OTHER**_____	**$**_____

E. REASON MEDICARE OR 'MY INSURANCE' MAY NOT PAY

☐ Your SpO2/PO2 is not below 88%/56mmHg	☐ You do not meet Medicare's requirements for use of item
☐ Your AHI/RDI is not > 15	☐ You are under a home health episode
☐ Medicare does not cover this item or upgrade	☐ Duplicate of service - Your Medicare benefits have been exhausted for this item
☐ We do not have documentation demonstrating medical necessity as required by Medicare	☐ We are not a Competitive Bid Winner for this product
☐ **Other:**	

F. ESTIMATED COST (SEE SECTION D ABOVE)

_____ I agree to pay these charges with bank or credit card information given by telephone unless other information provided here: Credit Card #_____ EXP_____ SC_____, or Account #_____ Routing #_____

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions you may have after you have finished reading.
- Choose an option below about whether to receive the item(s) listed in Section D above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare or MY INSURANCE cannot require us to do this.

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

☐ **Option 1.** I want the items listed in **Section D** above. You may ask to be paid now, but I also want Medicare or MY INSURANCE billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN) or EOB. I understand that if Medicare or MY INSURANCE doesn't pay, I am responsible for payment, but I can appeal to Medicare or MY INSURANCE by following the directions on the MSN or EOB**.** If Medicare or MY INSURANCE does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **Option 2.** I want the items listed in **Section D** above, but do not bill Medicare or MY INSURANCE. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare or MY INSURANCE is not billed.

☐ **Option 3.** I don't want the items listed **Section D** above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare or MY INSURANCE would pay.

This notice gives our opinion, not an official Medicare or MY INSURANCE 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**) or MY INSURANCE benefits department.

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature of Patient (or CAREGIVER)	Printed Name	Relationship to Patient	J. Date
_____	_____	_____	_____