A. Notifier: Casey Eye - Dept. of Ophthalmology- 93-1283717

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Ocular Lab Test 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.** Ocular Lab Test below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Autoimmune Retinopathy Panel by Immunoblot CAR Panel by Immunoblot and IHC MAR Panel by Immunoblot and IHC Anti-bestrophin Autoantibodies AMD Panel by Immunoblot Western blot for anti-retinal autoantibodies in follow up cases Western blot for anti-optic nerve autoantibodies in the serum Western blot for anti-optic nerve autoantibodies in CSF	Medicare does not pay for screening, experimental or off-label testing. This reference/research lab is not enrolled in the Medicare program.	$737.00 $895.00 $684.00 $95.00 $463.00 $684.00 $405.00 $405.00

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.** Ocular Lab Test 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.** _____ 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.** _____ 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.** _____ 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 also receive a copy.

I. Signature:	J. Date:
Notice of non-coverage only, no signature needed	

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