HOMECARE MEDICINE *of* ATLANTA

ADVANCED BENEFICIARY NOTICE (ABN)
For Medicare Patients Only

Presented by **HomeCare Medicine of Atlanta** to: _____
(Print name of patient or responsible party)

As you know, Medicare does not pay for all your medical expenses, even some services that you or your physician have good reason to think you need. Medicare does not pay for the services listed below, which means you are responsible for payment at the time of service and/or when indicated by HCMA.

	SERVICES	COST	REASON
1.	Trip Fee <20 miles	$50	Not a covered benefit
	Trip Fee >20 miles	$100	Not a covered benefit
	(WAIVED for post discharge patients and patients in domiciliary settings)		
2.	'No Show' Fee	$75	Not a covered benefit
3.	Cancellation Fee (<24 hours' notice)	$75	Not a covered benefit
4.	Late Fee	$25	Not a covered benefit
5.	Returned Check Fee	$35	Not a covered benefit
6.	Medical Clearance Fee	$100	Not a covered benefit
7.	Annual enrollment fee	$75	Not a covered benefit
	(Primary care patients in domiciliary settings ONLY)		
8.	Form fee and other Administrative services	$25	Not a covered benefit
	By office staff, upon patient/family request (excluding Home Health related requests)		

3330 Cumberland Blvd.
Ste 500
Atlanta, GA 30339
www.hcmatl.com

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1.770.740.2611 Local
1.770.800.3100 Fax
info@hcmatl.com

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OPTIONS:	**You must choose only one option below.**

_____ **OPTION 1**. I want the services listed above when applicable to my care, except those I crossed out. I will pay for them at the time of service, but I also want you to bill Medicare for an official decision on payment, which I can appeal if payment is denied. If Medicare does pay, you will refund any payment I made, less co-pays or deductibles.

_____ **OPTION 2**. **I want the services listed above when applicable to my care**, except those I crossed out, and agree to pay for them because I understand that those services are not covered by Medicare or supplemental insurance.

_____ **OPTION 3.** I don't want the services listed above. I will not be billed and I cannot appeal to see if Medicare would pay.

_____ _____

Signature **Date**

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