**Skilled Nursing Facility:**
**Address:**
**Phone Number:** **Patient's Name:**

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

Medicare does not 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. The care(s) you have been receiving during the Inpatient Skilled Nursing Facility include:

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Daily Skilled Nursing Care
- ☐ Other: _____

These care(s) are no longer occurring daily. As a result, **Medicare May Not Pay** for your Inpatient Skilled Nursing Facility due to the **following reason(s)**:

_____

**We estimate that these services will cost you $**_____ **per day/item or service.**

**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 cannot require us to do this.

| **OPTIONS:** **Check only one box. We cannot choose a box for you.** |
|---|
| ☐ **Option 1.** I want the daily skilled care listed above, which includes custodial services and room and board charges. 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 does not pay, I am responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN. |
| ☐ **Option 2.** I want the care(s) listed above, which includes custodial services and room and board charges, but do not bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. **I cannot appeal because Medicare will not be billed.** |
| ☐ **Option 3.** I do not want the care(s) listed above, I understand that I am not responsible for paying, and **I cannot appeal to see if Medicare would pay**. Medicare Part B may cover some of my care, excluding Room and Board, for which I would be responsible for paying. |

**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 have received and understand this notice. You will also get a copy for your records.

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

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