A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ 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.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
SKIN TAG REMOVALS, WARTS, ALOPECIA, SKIN LESIONS, LASER TREATMENTS, AND BENIGN DESTRUCTIONS	NOT MEDICALLY NECESSARY	$100 & UP

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.**_____ 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:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

INTEGRATED DERMATOLOGY OF YUMA

Ronald M. Harris, MD
Sandra Corbin, PA-C
Taylor Todd, PA-C

REGISTRATION INFORMATION

PATIENT INFORMATION **DATE:**

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX: ☐MALE ☐FEMALE

SPOUSE'S NAME	HOME #	WORK #

EMAIL ADDRESS	MOBILE #	MARTIAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED

RESPONSIBLE PARTY INFORMATION (If other than self)

LAST NAME	FIRST NAME	MI	HOME #

ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #

EMPLOYER	OCCUPATION	WORK #

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐ DAUGHTER

MOTHER'S NAME	MOTHER'S BIRTHDATE	FATHER'S NAME	FATHER'S BIRTHDATE

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT	OCCUPATION	EMPLOYMENT OR STUDENT STATUS:

PATIENT'S EMPLOYER OR SCHOOL ADDRESS	☐FULL-TIME ☐PART-TIME ☐SELF EMPLOYED

CITY	STATE	ZIP	☐NOT EMPLOYED ☐ACTIVE MILITARY ☐RETIRED

EMERGENCY INFORMATION

NAME	RELATIONSHIP	HOME #

ADDRESS	CITY	STATE	ZIP	WORK #

INSURANCE INFORMATION ☐ PPO ☐ POS ☐ MEDICARE ☐ HMO CO-PAY $

PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER	EFFECTIVE DATE

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

SECONDARY INSURANCE	CARDHOLDER	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER	EFFECTIVE DATE

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

PHARMACY INFORMATION-Must provide complete address information to ensure your prescriptions are sent to the correct pharmacy.

PHARMACY NAME	PHARMACY PHONE NUMBER

ADDRESS	CITY	STATE	ZIP