Dr. Edward Lang
Surgery of the Foot and Ankle

ADVANCE BENEFICIARY NOTICE (ABN)

You need to make a choice about receiving these health care items or services. We expect that Medicare as well as most private and commercial insurance carriers will not pay for the item(s) described below. Insurance carriers will not pay for certain treatments that they consider to be "routine" unless certain guidelines and rules are met. The fact that your insurance carrier may not pay for a particular item or service does not mean that you should not receive it, especially if your physician has recommended it. At this time, unless you are a documented diabetic, Medicare and most insurance carriers will **not** reimburse you for the following:

- Cutting or removal of corns and calluses
- Trimming, cutting, clipping, or debriding of toenails
- _____ (to be filled in by NOPA staff)

The purpose of this form is to help you make an informed decision about whether or not you will accept treatment for these non-covered services. If you do not understand why Medicare or your insurance carrier will not cover certain items or treatments, please ask us for a detailed explanation or ask us for pricing for the non-covered services that your physician has recommended or for the non-covered services that you are requesting to be performed through New Orleans Podiatry Associates.

Please check one option, sign, and date.

☐ **Option 1:** I will pay for my non-covered services at each visit; however, I also want Medicare or my insurance carrier billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN) or EOB statement. I understand that if Medicare or my insurance carrier does not pay, I will not be reimbursed for the non-covered services I received; however, **I can appeal to Medicare** by following the directions on the MSN. If Medicare or my insurance carrier does pay for the services, NOPA, Medicare, or my insurance carrier will refund any payments I made for these non-covered services, less co-payments or deductibles.

☐ **Option 2:** I will pay for non-covered services at every visit, as this is considered my financial responsibility. I do not wish for Medicare or my insurance carrier to receive a bill. **I understand that I cannot appeal if Medicare or my insurance carrier is not billed**.

☐ **Option 3:** I decline to receive any non-covered services.

Signature_____ Date_____

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