Sample ABN

Advance Beneficiary Notice of Non-coverage or ABN is a notice the hospital or doctor gives you before you're treated, telling you that Medicare will not pay for some treatment or services. The notice is given to you so that you may decide whether to have the treatment and how to pay for it.

Basic information– This provides you with the Notifier, or WRH and your name and Identification number

Notifier: Western Reserve Hospital, 1900 23rd Street, Cuyahoga Falls, OH 44223 (330) 971-7000

Patient Name: **Identification Number:**

Notice regarding Medicare payment

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the items and services listed below, 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 items and services below.

Services and items that have been prescribed to you, followed by the reason Medicare may not pay for them, finally the estimated cost and total estimated cost should Medicare decline to pay.

Items and Services	Reason Medicare May Not Pay:	Estimated Cost

Important things to know to help you make an informed decision

WHAT YOU NEED TO DO NOW: **TOTAL ESTIMATED COST:** ____________

- 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 items and services 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.

OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the items and services 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 items and services 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 items and services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Options:

1-check here to have the items or services listed and to bill Medicare for an official decision. You accept responsibility if Medicare does not pay, however you can appeal to Medicare.

2-check here to have the items or services, and not bill Medicare. You are responsible for payment and cannot appeal to Medicare.

3-Decline to have the services or items provided and not accept responsibility for payment.

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.

Signature:	**Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Sample Statement

Statement: Printed summary of your medical bill before insurance has paid any amount.

Notice of claim submission to your insurance company.

Customer Service Contact Information

Reminder that this is not a bill

Account Summary: Your unique account number, service location where you received treatment and your name

List of services you received and charges sent to your insurance company for processing

Remittance portion-not needed to be filled out for statement

900 23rd St
Cuyahoga Falls OH 44223

RETURN SERVICE REQUESTED

PHONE 330-255-3101

ACCOUNT SUMMARY

STATEMENT DATE	ACCOUNT NUMBER
07/27/2017	

SERVICE LOCATION
Western Reserve Hospital

PATIENT NAME

Page 1 of 1

IMPORTANT BILLING INFORMATION

Thank you for selecting Western Reserve Hospital for your health care needs. Quality patient care and dedication to patient satisfaction are our highest priority.

We have submitted your claim for the above date of service to your insurance carrier.

You will be billed for any balance after your insurance pays.

Please keep this statement as a record of services received.
If you have any questions, please contact Customer Service:

330-255-3101
Monday - Friday
9:00 am - 12:00 pm and
1:00pm - 4:30pm

Financial assistance is available for those in need. Please see the back of this statement for financial information.

ATTENTION

THIS IS NOT A BILL

DATE	DESCRIPTION	QTY	AMOUNT
07/14/17	LABORATORY	1	$45.00
07/14/17	CHEMISTRY	2	$688.00
07/14/17	HEMATOLOGY	1	$158.00
07/14/17	LABORATORY UROLOGY	1	$107.00
07/21/17	UNITED HEALTHCARE CSA		-$800.60
07/26/17	UNITED HEALTHCARE CSA		$800.60

www.westernreservehospital.org
Visit us online!

Please complete and return if any information has changed.

CONTACT INFORMATION CHANGE

ACCOUNT NUMBER:

RESPONSIBLE PARTY NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

HOME TELEPHONE DAYTIME TELEPHONE

Send to:

WESTERN RESERVE HOSPITAL
1900 23RD ST
CUYAHOGA FALLS OH 44223

INSURANCE UPDATE

INSURANCE COMPANY NAME / GROUP POLICY NUMBER

CLAIM MAILING ADDRESS

POLICYHOLDER NAME

EFFECTIVE FROM EFFECTIVE TO

POLICY HOLDER'S EMPLOYER NAME

PERSONS COVERED BY POLICY

Sample Bill

Bill: Printed summary of your medical bill after insurance has received it. This document tells you what you might owe after insurance.

Patient Financial Services Contact information

Notice that your claim has been processed by your insurance. This lets you know that this is indeed a bill

Payment remittance-turn this in with your payment if sending by mail

WESTERN RESERVE HOSPITAL

1900 23rd St
Cuyahoga Falls OH 44223

RETURN SERVICE REQUESTED

PHONE 330-255-3101

ACCOUNT INFORMATION

STATEMENT DATE 08/10/2017
ACCOUNT NUMBER
SERVICE LOCATION Western Reserve Hospital
PATIENT NAME

CONTACT INFORMATION

Call Patient Financial Services:
330-255-3101
Monday - Friday
9:00 am - 12:00 pm and
1:00 pm - 4:30 pm

Visit us online at:
www.westernreservehospital.org

IMPORTANT MESSAGE

Your insurance has processed, and the balance due is your responsibility. Payment is due upon receipt of statement.

Page 1 of 1

DATE	DESCRIPTION	QTY	AMOUNT	BALANCE
	Previous Balance			$16,525.00
07/12/17	PHARMACY	2	$247.00	
07/12/17	STERILE SUPPLY	1	$1,266.00	
07/12/17	LABORATORY PATHOLOGICAL HISTO	2	$880.00	
07/12/17	OR SERVICES	1	$9,665.00	
07/12/17	ANESTHESIA	2	$1,243.00	
07/12/17	DRUGS REQ DETAILED CODING	27	$491.00	
07/12/17	SELF ADMINISTERED DRUGS	1	$26.00	
07/12/17	RECOVERY ROOM	10	$2,707.00	
07/24/17	MANAGED CARE CSA		-$14,426.00	
08/03/17	MANAGED CARE CSA		-$14,425.97	
08/09/17	MANAGED CARE CSA		$14,426.00	
08/03/17	OTHER COMMERCIAL INS		$.00	
08/03/17	Ded = 2099.03			
	Balance			$2,099.03

IMPORTANT FINANCIAL ASSISTANCE INFORMATION ON BACK

Please Pay This Amount

DUE: Aug 24, 2017
$2,099.03

Please return bottom portion with your payment.

DUE DATE	Statement Date
August 24, 2017	August 10, 2017
Responsible Party	Account Number

Make check payable to
Western Reserve Hospital

AMOUNT ENCLOSED:
$

Please Pay This Amount
$2,099.03

❑ Please check if address and insurance has changed and indicate change on reverse side.

WESTERN RESERVE HOSPITAL
PO BOX 94577
CLEVELAND OH 44101-4577

FILL OUT BELOW FOR CREDIT CARD PAYMENTS

❑ VISA ❑ ❑

PRINT NAME ON CARD
$ PAYMENT AMOUNT
CARD NUMBER
EXPIRATION DATE
SIGNATURE

Account information– your account number is your unique identifier. Use this information when you are calling customer service or when processing a payment online

Quantity: The total number of billing units associated with each description. Note: Units are determined by the CPT Code definition and could be based on time increments, drug dosage, etc.

List of services you received and charges sent to your insurance company for processing

CSA=Contractual Adjustment. We estimate this amount at the time of billing but the amount may change after your insurance processes the claim

The amount you owe

Sample Estimate

Estimate: An approximate calculation of the amount you will be responsible for paying after insurance.

Your unique insurance information

Deductible, Out of Pocket, Co-Pay and Co-insurance information applied at the time of estimate

Estimated amount due after Deductible, Co-Pay and Co-insurance have been applied.

Common billing definitions to help you understand your estimate, statement, bill, etc.

CPT (test codes) and ICD-10 (diagnosis codes) taken from your physician's order to run the esti-

Disclaimer: Estimates may change due to various reasons. Read carefully to understand how the esti-

WESTERN RESERVE HOSPITAL
Proudly Physician Owned

Western Reserve Hospital
1900 23rd Street
Cuyahoga Falls, OH 44223-1404
Phone: 330-971-7597

ESTIMATE WORKSHEET

Patient Name: Deanna Test Phone:(330) 999-9999
Service Date: 5/18/2017
Account #: 000000000
Policy Number:
Group Number:
Insurance Company: Medical Mutual of Ohio (MMO) - Traditional

This estimate is based on the following codes:
Facility Codes (CPT®):
70553 TC : MRI BRAIN STEM W/O & W/DYE

ICD-10's:
R51 (Diag) : HEADACHE

Deductible:	$100.00
Deductible Met:	$100.00
Out of Pocket Max:	$650.00
Out of Pocket Met:	$225.00
Co-Pay:	$0.00
Co-Insurance:	20%

Co-Pay:	$0.00
Deductible:	$0.00
Co-Insurance:	$425.00
Total:	$425.00

Total Estimated Charges
$9,814.00

Total Estimated Patient Amount
$425.00

Ins Rep: Test - (000) 000-0000 - 05/18/2017

CPT copyright 2017 American Medical Association. All rights reserved.

Est ID: 5237

THIS IS AN ESTIMATE ONLY

We are very pleased that you have chosen Western Reserve Hospital for your healthcare services. Please be aware that this estimate may change due to changes in pricing or any change in your insurance coverage. Please contact us to allow us to update this estimate as needed. The above costs associated with your visit are an ESTIMATE of your portion of the balance, based on your insurance benefits. Please remember that the contract with your insurance company is ultimately your responsibility. We recommend that you contact your insurance company to inform them of your visit and verify that they have all of the information they will need to process and approve claims. We will honor any contracts we may have with them; however, you are responsible for your deductible, co-payment, and/or co-insurance. These benefits are only an estimate of coverage and not a guarantee of payment. For questions please call (330) 971-7597.

Definitions

Deductible: The amount you have to pay each year before your plan starts paying benefits

Out of Pocket: The amount your insurance company requires you to pay before you are no longer subject to co-insurance

Co-Pay: The amount that your insurance company expects you to pay upon each visit/service

Co-Insurance: The percentage of the amount covered that your insurance requires you to pay

Total Estimated Charges: The estimated charge(s) for the service provided

Total Estimated Patient Amount: The estimated amount you will be responsible for paying

OFFICE USE ONLY

Date:

Notes:

Prepared By: 88617

Sample Financial Assistance Application

Patient Financial Services Contact information

Notice Regarding Free Care– Information regarding qualifications to receive free care.

Hospital Care Assurance Application– This form must be filled out completely and returned to Patient Financial Services with proof of income for 3 months prior to month of service

Reminder to complete application even if you do not seem to fall under the poverty guidelines.

Poverty Guidelines for qualification of assistance.

Specifics regarding family size and income.

Reminder that applications need to be updated every 90 days and for every inpatient stay.

Mail to: Western Reserve Hospital
Attn: Patient Financial Services
1900 23rd Street
Cuyahoga Falls, Ohio 44223

Phone: 330-255-3101
Fax to: 330-928-3005

Complete application even if your income is more than the below to be considered for other programs.

Family Size	Yearly Income
1	12,060
2	16,240
3	20,420
4	24,600
5	28,780
6	32,960
7	37,140
8	41,320
For each additional family member add $4,160	

NOTICE REGARDING FREE CARE

Under State law, this hospital must provide, without charge, certain Basic Medically Necessary Hospital Services to individuals who meet all of the following requirements:

1. Individuals must be residents of the State of Ohio,
2. Individuals cannot be enrolled in the Medicaid Program, and
3. Personal or family income is at or below the Federal Poverty Line.

Basic Medically Necessary Hospital Services include all inpatient and outpatient services covered under the Medicaid Program, except organ transplants and associated services. **These programs do not cover any Physician services or professional billing fees.**

If you have any questions, please call us at 330-255-3101
You may also pay your bill on line at: http://www.westernreservehospital.org/billpay.

HOSPITAL CARE ASSURANCE APPLICATION

Patient's Name ______________________ Patient's Social Security # ______________ Patient's Date of Birth ____________

☐ Single ☐ Married ☐ Widowed Employment status at time of service ☐ Employed ☐ Retired ☐ Unemployed

Were you a resident of Ohio at time of service ☐ Yes ☐ No

Were you an active Medicaid recipient at time of service? ☐ Yes ☐ No

Were you an active recipient of Disability Assistance (DA) benefits at the time of service? ☐ Yes ☐ No

"Family" members include patient, patient's spouse (regardless of whether they live in the home) and patient's children (natural or adoptive) under the ag eighteen (18) who live in the home. If patient is under the age of 18, "family" includes the patient, patient's natural or adoptive parent(s) (regardless of whether ive in the home) and the parents' children under the age of 18 who live in the home.
Income includes household gross (pre-tax) wages, unemployment compensation, social security benefits, public assistance, etc. **Please attach proof of inc such as all pay stubs for 3 months prior to month of service, letter of SSI/SSD/VA/ Unemployment benefits.**

Family Member's Name	Date of Birth	Relationship To Patient	Source of Income or Employer Name	Income for 3 months Prior to service date
(Patient)		SELF		
(Spouse)				

If you reported $0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested abov
$0 INCOME STATEMENT:

I affirm that the answers on this application are true, and I understand that it is unlawful to knowingly submit false information to obtain government benefits.
Signature of patient or legal representative of patient ______________________ Date: ________

A new or updated application is required every 90 days and for every inpatient hospital stay.

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