Company Name

OMB APPROVAL NO. 0938-0781

HOME HEALTH ADVANCE BENEFICIARY NOTICE (HHABN)

We,______________________________, your home health agency, are letting you know that we will be providing you with the following items and/or services:

____

____

Because: ____

____

If you have questions about these changes, you can call us at: (______) ____________________.
TTY users should call: (______) ____________________.

The estimated cost of the items and/or services listed above is $ ______________________________

____

If you have other insurance, please see number 3 below.

You have three options available to you. You must choose only one of these options by checking the box next to the option and then signing below:

☐ 1. I don't want the items and/or services listed above. I understand that I won't be billed and that I have no appeal rights since I will not receive those items and/or services.

☐ 2. I want the items and/or services listed above, and I agree to pay myself since I don't want a claim submitted to Medicare or any other insurance I have. I understand that I have no appeal rights since a claim won't be submitted to Medicare.

☐ 3. I want the items and/or services listed above, and I agree to pay for the items and/or services myself if Medicare or my other insurance doesn't pay. Send the claim to **(please check one or both boxes):**
☐ Medicare
☐ My other insurance ____

Please note: If you choose option 3 and a claim is submitted to Medicare, you will get a Medicare Summary Notice (MSN) showing Medicare's official payment decision. If the MSN indicates that Medicare won't pay all or part of your claim, you may appeal Medicare's decision by following the appeal procedures in the MSN. If you don't receive a MSN for your claim, you can call Medicare at: 1-800-633-4227. TTY: 1-877-486-2048.

You may have to pay the full cost at the time you get the items and/or services. If Medicare or your other insurance decides to pay for all or part of the items and/or services that you have already paid for, you should receive a refund for the appropriate amount.

By signing below, I understand that I received this notice because this Home Health Agency believes Medicare will not pay for the items/services listed, and so I chose the option checked above.

Patient's Name ______________________________ Patient Identification ____________________

Signature of the Patient
or of the Authorized Representative ______________________________ Date______________

Please read and sign this notice. Return it to us or mail it to our address listed above.

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