

ADVANCE BENEFICIARY NOTICE (ABN) & WAIVER OF LIABILITY
REQUIRED BY MEDICARE

BIO-CENTER LABORATORY, 3100 North Hillside, Wichita, KS 67219, Tel 316-682-3100, Fax 316-682-2062

Patient Name (First, Middle Initial, Last)		Medicare Number
Patient Date Of Birth (DD-MM-YYYY)	_____ M / F Patient's Age & Gender	Date of Service
Street Address & Apartment #		City , State, Zip (required)
Patient Telephone Number	Physician's Name	Physician's UPIN #
ICD-9 Diagnosis Codes	\$ _____ . _____ Total Lab Test Fees	\$ _____ . _____ Non-covered Fees (due today)

The ordering physician must be a Medicare provider in order for services to be filed with Medicare.

Medicare requires that the patient sign its waiver on the date of service for covered services only. The waiver must accompany the specimen and requisition. Payment must accompany non-covered services.

Medicare does not pay for routine testing or screening. Medicare does not pay for testing if the patient is enrolled in Hospice.

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. **Medicare does not cover some of the tests performed here, since some are consider "preventive". Medicare pays only for tests it considers "medically necessary". I believe in your case, Medicare is likely to deny payment for the service(s) indicated below for the following reasons (see the following four categories):**

Category 1: Medicare does not consider any of the following tests a medical necessity. Medicare has advised the lab not to file non-covered services. Therefore, **full payment is required at the time of service for the following tests, which will not be filed with Medicare:**

- | | | |
|------------------|------------|------------------|
| Indican, Urine | Spermidine | Vitamin C, Urine |
| Pyrrroles, Urine | Spermine | |

In the remaining categories below, please place an “X” beside the test(s) that you are submitting to Bio-Center Laboratory for testing services. We will file these services with Medicare on your behalf.

Category 2: On the following laboratory tests, Medicare usually covers these tests except when it deems the diagnosis (determined by the physician) does not support the medical necessity. A completed and signed Waiver of Liability must be submitted with the specimen, along with a copy of the patient’s Medicare card. **Payment is not required at the time of service for these tests, which will be filed with Medicare:**

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> <i>Candida</i> IgG, IgA, IgM | <input type="checkbox"/> Epstein Barr Virus | <input type="checkbox"/> Homocysteine | <input type="checkbox"/> Sodium/Potassium, Urine |
| <input type="checkbox"/> Creatinine | <input type="checkbox"/> G6PD | <input type="checkbox"/> Lipoprotein (a) | <input type="checkbox"/> Stool Profile |
| <input type="checkbox"/> CRP (C-Reactive Protein) | <input type="checkbox"/> <i>Giardia/Cryptosporidium</i> Ag | | <input type="checkbox"/> T ₃ , Free (Unbound) |
| <input type="checkbox"/> DHEA | <input type="checkbox"/> <i>H. Pylori</i> Ab | <input type="checkbox"/> Sedimentation Rate | |

Category 3: An Advanced Beneficiary Notice (ABN) form is required for these limited coverage tests. These tests are usually covered, but may be denied by Medicare when it deems the diagnosis (determined by the physician) does not match the ICD-9 codes established as eligible for coverage by Medicare. Also, these tests may be denied if any particular one or more of these limited coverage tests have been ordered too frequently within a particular time frame. The following tests will be filed with Medicare. Therefore, **payment is not required at time of service. Medicare requires a completed and signed ABN and a copy of the patient’s Medicare card along with the specimen.**

- | | | | |
|--------------------------------------|--|--|-------------------------------------|
| <input type="checkbox"/> CBC | <input type="checkbox"/> Fructosamine (Glycated Protein) | <input type="checkbox"/> Lipid Profile | <input type="checkbox"/> TSH |
| <input type="checkbox"/> CEA | <input type="checkbox"/> Glucose &/or GTT ____hrs | <input type="checkbox"/> PSA | <input type="checkbox"/> Urinalysis |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Hemocult (Occult Blood) | | |

Category 4: The following tests are sent to a reference lab by Bio-Center Laboratory and require an ABN form from the reference lab that performs the testing. Please call or fax BCL to request an ABN for these tests prior to specimen collection:

- | | | |
|---|---|---|
| <input type="checkbox"/> ASO Titer | <input type="checkbox"/> Hepatic Panel * | <input type="checkbox"/> Metabolic Panel, Comprehensive * |
| <input type="checkbox"/> <i>Chlamydia</i> Diff Ab Panel | <input type="checkbox"/> Immunoglobulins IgG, IgA, IgM, IgE | <input type="checkbox"/> Organic Acids, Urine |
| <input type="checkbox"/> CK Isoenzymes | <input type="checkbox"/> Insulin | <input type="checkbox"/> Progesterone |
| <input type="checkbox"/> <i>Cytomegalovirus</i> IgG | <input type="checkbox"/> Metabolic Panel, Basic * | <input type="checkbox"/> Thyroid Profile |
| <input type="checkbox"/> Electrolyte Panel * | | |

* For chemistry panels, choose from the Medicare-approved panels listed in Category 4 with an asterisk (*).

BENEFICIARY AGREEMENT

My physician has notified me that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for the payment. Any tests denied by Medicare are due upon receipt of the statement.

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Bio-Center Laboratory for any services furnished to me by BCL. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____	____/____/____
Patient’s signature	Date (DD/MM/YYYY)

MEDICARE HAS ADVISED THE LAB NOT TO FILE NON-COVERED SERVICES.