MAXIMILIAN MEDICAL, LLC.
100 Commerce Way, #5, Hackensack, NJ 07601 | Phone: 201-880-7802 | Fax: 201-880-7804

Advance Beneficiary Notice of Non-coverage (ABN)

1 Patient Name	2 Identification Number (optional)

3 Item	4 Estimated Cost
5 Reason Medicare, Medicaid or your third party private health insurance May Not Pay	

NOTE: If Medicare, Medicaid or your third party private health insurance doesn't pay for 3 ______________________________
You may have to pay. Medicare, Medicaid or your third party private health insurance 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, Medicaid or your third party private health insurance may not pay for 3 ______________________________

WHAT YOU NEED TO DO NOW:

- Read this notice so you can make an informed decision about your care
- Ask us any questions you may have after you finish reading
- Choose an option below about whether to receive the 3 ______________________________ listed above.

NOTE: If you chose option 1 or 2, we may assist all other insurance's that you may have, **however** we are **NOT**

6 **OPTIONS:** Check only one box. We cannot choose a box for you.	
☐	**OPTION 1.** I want the 3 ____________________ listed above. You may ask to be paid now, but I also want Medicare, Medicaid or my third party private health insurance billed for an official decision on payment, which is sent to me on an EOB Summary Notice. I understand that ifMedicare, Medicaid or my third party private health insurance doesn't pay, I am responsible for payment, but I can appeal to Medicare, Medicaid or my third party private health insurance by following the directions on the EOB. If Medicare, Medicaid or my third party private health insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐	**OPTION 2.** I want the 3 ____________________ listed above, but do not bill Medicare, Medicaid or my third party private health insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare, Medicaid or my third party private health insurance is not billed.
☐	**OPTION 3.** I don't want the 3 ____________________ listed above. I understand with this choice I'm not responsible for payment, and I cannot appeal to see if my insurance will pay

7 Additional Information

THIS ABN NOTICE gives our opinion, not an official decision whether your health insurance will pay or not. If you have other questions regarding this notice or other areas of your health insurance billing. Please contact your health insurance company directly. For Medicare: 1-800-633-4227. For Medicaid and /or your 3rd party private health insurance company, we are happy to assist with providing you with their contact phone number.

Signing below indicates that you have received and understand this notice. You also have received a copy

8 Signature	9 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 5 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.