9362 W. Overland Rd. • Boise, Idaho 83709 • (208)672-8144 • Fax (208)672-8145
www.aptorthosports.com • aptboise@aol.com

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

THERE ARE ITEMS AND SERVICES FOR WHICH MEDICARE **WILL NOT PAY.**

Medicare requires us to remind you that they do NOT pay for ALL of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.

When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

You have the right to ask us to explain if you don't understand why Medicare will not pay, and the right to ask how much these items or services will cost you.

2017 EXCLUDED SERVICES

Medicare will not pay for physical therapy and speech-language therapy over $*1980* annually from *January 1, 2017 through December 31, 2017.* When this maximum allowable amount is reached, none of your therapy services will be covered by Medicare, and you will be responsible for payment, either personally or through other insurance. The Medicare deductible for 2017 is $183.

*This is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

I have read and understand this *Notice of Exclusion of Medicare Benefits*. I understand that Medicare will not pay for therapy services in excess of $1960 annually. I agree to be responsible for payment in full of services that exceed this amount (either personally or through other insurance.)

*I **have/have not** received physical therapy services this calendar year prior to this date. (Previous therapist_____.)*

Signed_____Date_____

Printed Name_____

Medicare#_____

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MEDICARE LIFETIME SIGNATURE ON FILE

NAME OF BENEFICIARY_____

MEDICARE NUMBER (HIC NUMBER)_____

I request that payment of authorized Medicare benefits be made to Advance Physical Therapy on my behalf for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS, formerly HCFA) and its agents any information needed to determine these benefits payable to related services.

MEDIGAP AND/OR SUPPLEMENTAL INSURANCE ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

INSURANCE COMPANY_____

POLICY NUMBER_____

I request that payment of authorized Medicare benefits be made to Advance Physical Therapy on my behalf for any services furnished me by that practice.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of information to that insurer or agency.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based on the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE_____

DATE_____

WITNESS_____

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ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you 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 **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. EST. Cost
1. 97039 – Phonophoresis	1. Not a covered benefit	$25.00
2. 99070 – Supplies	2. Not a covered benefit	Varies

WHAT YOU NEED TO DO NOW:

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 **D.** _____ 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.

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

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

H. 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.

I. Signature:	J. Date: