Print your name, address and telephone number. Logo is optional.

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the items or services 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 items or services below.

Items or Services	Reason Medicare May Not Pay:	Estimated Cost:
☐ The intraocular lens (IOL) upgrade ☐ Laser for refractive surgery See attachment for details.	Medicare statutory exclusion, coverage policy limitation, or other restriction. See attachment for details.	$_____

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 _____ 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 or 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 or services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment, and **I cannot appeal if Medicare is not billed.**

[ ] OPTION 3. I don't want the items or services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

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:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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Print your name, address and telephone number. Logo is optional.

Patient Name: **Identification Number:**

Attachment to Advance Beneficiary Notice of Noncoverage (ABN)

Items or Services	Reason Medicare May Not Pay:	Estimated Cost:
☐ The intraocular lens (IOL) upgrade from a conventional lens to a presbyopia-correcting or astigmatism-correcting lens	Medicare has established specific policies* concerning presbyopia-correction and astigmatism-correction that declare these added items and services to be not covered and the financial responsibility of the beneficiary. * CMS Ruling No 05-01 (May 3, 2005), *and* Transmittal 636 (August 5, 2005) *and* CMS Ruling No 1536-R (January 22, 2007)	**$_____**
☐ The use of a femtosecond laser in refractive cataract surgery for making arcuate corneal incisions	National Coverage Determination §80.7 specifies that *"...keratoplasty for the purpose of refractive error compensation is considered a substitute or alternative to eyeglasses or contact lenses, which are specifically excluded . . . keratoplasty to treat refractive defects are not covered."*	**$_____**

Signing below means that you have received and understand this attachment to the ABN. You also receive a copy.

Signature:	**Date:**