MMS MILITARY MEDICAL SUPPLIES
Serving Those Who Serve America

CALMED HAWAII
Your Choice For Better Patient Care

PATIENT NAME: _____ Identification Number: _____

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If _____ Primary Insurance (PI) doesn't pay for D. _____ below, you may have to pay. PI does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect PI may not pay for the D _____ below.

D.	E. Reason _____ May Not Pay:	F. Estimated Cost:

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. product or service listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but PI 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 PI billed for an official decision on payment, which is sent to me on a Summary Notice (SN). I understand that if PI doesn't pay, I am responsible for payment, but I can appeal to PI by following the directions on the SN. If PI 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 PI. You may ask to be paid now as I am responsible for payment. I cannot appeal if PI 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 PI would pay.

H. Additional Information:

This notice gives our opinion, not an official PI decision. If you have other questions on this notice or billing, call 1-800-270-6990. Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: