

Patient Name In Full \_\_\_\_\_

Medical Record Number \_\_\_\_\_

**NOTE:** 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 laboratory test(s) checked or listed below.

<input type="checkbox"/> <b>Medicare does not pay for these laboratory test(s) for your condition</b>		<input type="checkbox"/> <b>Medicare may not pay for these tests as often as this (denied as too frequent)</b>	
<input type="checkbox"/> Alpha 1 Fetoprotein <input type="checkbox"/> Blood Smear (PBS) <input type="checkbox"/> CA 125 <input type="checkbox"/> CA 15-3 (27.29) <input type="checkbox"/> CA 19-9 <input type="checkbox"/> Carnitine <input type="checkbox"/> CBC/Hemogram <input type="checkbox"/> CEA <input type="checkbox"/> Chlamydia trach <input type="checkbox"/> Cholesterol <input type="checkbox"/> Collagen Cross Links <input type="checkbox"/> CRP-High Sens <input type="checkbox"/> CMV <input type="checkbox"/> Digoxin <input type="checkbox"/> Drug Screen <input type="checkbox"/> Other: _____	<input type="checkbox"/> Ferritin <input type="checkbox"/> Fibrinogen <input type="checkbox"/> Flow Cytometry <input type="checkbox"/> Folate <input type="checkbox"/> Fructosamine <input type="checkbox"/> GC (N. gonorrhea) <input type="checkbox"/> Glucose, Blood <input type="checkbox"/> Glycohgb (A1c) <input type="checkbox"/> GT <input type="checkbox"/> H. Pylori <input type="checkbox"/> HCG, Quantitative <input type="checkbox"/> HDL, Serum <input type="checkbox"/> Hematocrit <input type="checkbox"/> Hemoglobin <input type="checkbox"/> Hepatitis C Genotype	<input type="checkbox"/> Hepatitis C Viral Load <input type="checkbox"/> Hepatitis Panel <input type="checkbox"/> HIV <input type="checkbox"/> Homocystine <input type="checkbox"/> Iron <input type="checkbox"/> LDL Direct <input type="checkbox"/> Lipid Panel <input type="checkbox"/> Molecular/PCR Testing for Infectious Diseases <input type="checkbox"/> N-Telopeptide <input type="checkbox"/> Occult Blood, Fecal <input type="checkbox"/> Platelet count <input type="checkbox"/> PSA, Free & Total <input type="checkbox"/> PSA, Total	<input type="checkbox"/> PT <input type="checkbox"/> PTT <input type="checkbox"/> T3 Uptake <input type="checkbox"/> T4, Free <input type="checkbox"/> T4, Total <input type="checkbox"/> TIBC/Transferrin <input type="checkbox"/> Triglyceride <input type="checkbox"/> Troponin <input type="checkbox"/> TSH <input type="checkbox"/> Urine Culture <input type="checkbox"/> Vitamin B6 <input type="checkbox"/> Vitamin B12 <input type="checkbox"/> Vitamin D, 25-OH <input type="checkbox"/> WBC
<input type="checkbox"/> <b>Medicare does not pay for experimental or research use as described in Other.</b>		<b>Estimated Cost \$</b> _____	

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us questions that you may have after you finish reading.
- Choose an option below about whether to receive the laboratory test(s) checked or 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 these laboratory test(s) checked or 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 laboratory test(s) checked or 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 laboratory test(s) checked or 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.

Patient - <i>Signature</i> _____		Date _____
Person Authorized to Sign for Patient _____	Relationship to Patient _____	Date _____

**TRANSLATION** - This is to certify that the above Notice has been read to the patient (or representative) in his/her native language; all representations which appear in the Notice were understood and authorized by the patient (or representative).

Form CMS-R-131 (03-11) Form Approved OMB No. 0938-0566 WHITE - Laboratory, CANARY - Patient 402-028P / 01-12	Interpreter - <i>Signature</i> _____	Date _____
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