SOUTHERN FAMILY MEDICINE LLC
Primary care for patients of all ages

16312 Mount Airy Road
Shrewsbury, Pennsylvania 17361
www.SouthernFamilyMed.com

Phone (from PA): (717) 227-3800
Phone (from MD): (410) 584-2600
Fax: (717) 227-3802

A. Patient Name: _____ **Nurse Initials:** _____

B. DOB: _____ **Site:** _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare/Insurance doesn't pay for **(D.)** **The Below Mentioned Item(s)/Service(s)**, you may have to pay. Medicare/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/Insurance may not pay for the **(D.)** **The Below Mentioned Item(s)/Service(s)**.

D. Item(s) or Service(s)	E. Reason Medicare May Not Pay:	F. Estimated Cost
☐ Influenza Vaccine High dose (65 and up) Flublok (18-64)	May Not Be Covered	$75.00
☐ Influenza Vaccine (6mo and up)	May Not Be Covered	$30.00

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.)** **The Above-Mentioned Item(s)/Service(s)**.
  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.)** **The Above-Mentioned Item(s)/Service(s)**. You may ask to be paid now, but I also want Medicare/Insurance billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN)/EOB. I understand that if Medicare/Insurance does not pay, I am responsible for payment, but **I can appeal to Medicare/Insurance** by following the directions on the MSN/EOB**.** If Medicare/Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **(D.)** **The Above-Mentioned Item(s)/Service(s)**, but do not bill Medicare/Insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare/Insurance is not billed**.

☐ **OPTION 3.** I do not want the **(D.)** **The Above-Mentioned Item(s)/Service(s)**, I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare/Insurance 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:

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.

INFLUENZA IMMUNIZATION QUESTIONNAIRE

	YES	NO
1. Are you currently sick with fevers, chills, cough, difficulty breathing or any other worrisome symptoms?	☐	☐
2. Do you have, or have you ever had a Guillain Barre Syndrome (a disorder causing paralysis)?	☐	☐
3. Are you currently pregnant?	☐	☐
4. Do you have a severe allergy to eggs?	☐	☐
5. Do you have any active or unstable neurological problems?	☐	☐
6. Do you have a history of a severe reaction to any vaccine?	☐	☐

I have read the Influenza Fact Sheet and understand the benefits and possible risks of the vaccine. Any questions I have were answered to my satisfaction.

PLEASE PRINT CLEARLY:

_____

Last Name First Name DOB

_____

Street Address City State Zip Code

_____

Phone Number Signature Date