A. Madison County EMS

556 South Keeneland Dr, Richmond KY 40475 Phone: (859) 623-5121 Fax: (859) 626-0340

B. Patient Name: _____ **C. Run Number:** _____

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If Medicaid doesn't pay for **ambulance services** below, you may have to pay. Medicaid does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicaid may not pay for the **ambulance services** below

D. Ambulance Services	E. Reason Medicaid May Not Pay:	F. Estimated Cost
☐ BLS Non-Emergency ☐ ALS Non-Emergency ☐ Mileage	Your insurance may decide the ambulance transport was not deemed Medically Necessary according to your policy guidelines.	☐ $ 475.00 ☐ $ 575.00 ☐ Mileage $15.00/mile

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 **ambulance services** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicaid cannot require us to do this.

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

☐ **OPTION 1.** I want the **ambulance services** listed above. You may ask to be paid now, and I understand that Medicaid may not be billable for the ambulance services above. I understand that since Medicaid may not pay, I am responsible for payment, but **I can appeal to Medicaid if they are billable** and If Medicaid does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **ambulance services** listed above, but do not bill Medicaid. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicaid is not billed**.

☐ **OPTION 3.** I don't want the **ambulance services** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicaid would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicaid decision.

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: