~~OMB Approval No. 0938-0781~~

Home Health Advance Beneficiary Notice (HHABN)

[*SAMPLE*]

We, _____ *(INSERT NAME OF HHA)* _____, your home health agency, are letting you know that we _____ (INSERT APPROPRIATE CLAUSE) _____ with the following items and/or services: *(DESCRIBE AFFECTED ITEM~~(S)~~ AND/OR SERVICE~~(SS)~~)* _____

Because: *(DESCRIBE APPROPRIATE REASON)* _____

If you have questions about these changes, you can call us at (____) _____
TTY users should call (____) _____.

INSERT:

OPTION BOX 1 TEXT:
USE WHEN ITEM~~(S)~~ AND/OR SERVICE~~(S)~~ MAY BE PROVIDED THAT WILL NOT BE PAID FOR BY MEDICARE.

OR

OPTION BOX 2 TEXT:
USE WHEN ITEM~~(S)~~ AND/OR SERVICE~~(S)~~ WILL NO LONGER BE PROVIDED FOR FINANCIAL AND/OR OTHER REASONS.

OR

OPTION BOX 3 TEXT:
USE WHEN PHYSICIAN'S ORDERS REDUCE CERTAIN ITEM~~(S)~~ AND/OR SERVICES.

Patient's Name	~~Medicare # (HICN)~~Patient Identification
Signature of the Patient or of the Authorized Representative	Date

Please read and sign this notice. Return it to us or mail it to our address listed above.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0781. The time required to complete this information collection is estimated to average 4 to 18 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form No. CMS-R-296 (~~06/2006~~08/2012)

OMB Approval No. 0938-0781 ~~*SAMPLE*~~

~~OMB Approval No. 0938-0781~~

Home Health Advance Beneficiary Notice (HHABN)

[Option Box 1 Sample]

We, _____, your home health agency, are letting you know that we _____ with the following items and/or services: _____

Because: _____

_____

If you have questions about these changes, you can call us at (____) _____
TTY users should call (____) _____.

The estimated cost of the items and/or services listed above is $ _____

_____

If you have other insurance, please see number~~#~~3 below.

You have three options available to you. You must choose only one of these options by checking the box next to the option and then signing below:

☐ 1. I don't want the items and/or services listed above. I understand that I won't be billed and that I have no appeal rights since I will not receive those items and/or services.

☐ 2. I want the items and/or services listed above, and I agree to pay myself since I don't want a claim submitted to Medicare or any other insurance I have. I understand that I have no appeal rights since a claim won't be submitted to Medicare.

☐ 3. I want the items and/or services listed above, and I agree to pay for the items and/or services myself if Medicare or my other insurance doesn't pay. Send the claim to (**Please check one or both boxes**):

- ☐ Medicare
- ☐ My other insurance: _____

Please note: If you select option 3 and a claim is submitted to Medicare, you will get a Medicare Summary Notice (MSN) showing Medicare's official payment decision. If the MSN indicates that Medicare won't pay all or part of your claim, you may appeal Medicare's decision by following the appeal procedures in the MSN. If you don't receive a MSN for your claim, you can call Medicare at: 1-800-633-4227~~(____) _____~~. TTY: ~~(____)~~ 1-877-486-2048.~~_____~~. You may have to pay the full cost at the time you get the items and/or services. If Medicare or your other insurance decides to pay for all or part of the items and/or services that you have already paid for, you should receive a refund for the appropriate amount.

By signing below, I understand that I received this notice because this Home Health Agency believes Medicare will not pay for the items/services listed, and so I chose the option checked above.

Patient's Name	Patient Identification~~Medicare # (HICN)~~
Signature of the Patient or of the Authorized Representative	Date

Please read and sign this notice. Return it to us or mail it to our address listed above.

gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form No. CMS-R-296 (~~06/~~08/2012)~~2006)~~ OMB Approval No. 0938-0781~~*OPTION BOX 1*~~

Home Health Advance Beneficiary Notice (HHABN)

[Option Box 2 Sample]

We, __________________ your home health agency, are letting you know that we ________________________ with the following items and/or services: ___________________________

Because: ____

If you have questions about these changes, you can call us at (____) ____________________
TTY users should call (____) ________________.

OMB Approval No. 0938-0781

Home Health Advance Beneficiary Notice

We, ____, your home health agency, are letting you know that we ____ with the following items and/or services:____
____
____
___

Because: ____
____
____

If you have questions about these changes, you can call us at (_____) _________________________
TTY users should call (_____)___________________.

By signing below, I understand that I received this notice because this Home Health Agency decided to stop providing the items and/or services listed above. The Agency's decision doesn't change my Medicare coverage or other health insurance coverage. I can't appeal to Medicare since this Home Health Agency won't provide me with any more items and/or services; however, I can try to get the items and/or services from another Home Health Agency.

Please note that there are many different ways to find another Home Health Agency, including by contacting your doctor who originally ordered home care. You may then ask the new Home Health Agency to bill Medicare or your other insurance for items and/or services you receive from them.

Patient's Name	~~Medicare # (HICN)~~Patient Identification
Signature of the Patient or of the Authorized Representative	Date

Please read and sign this notice. Return it to us or mail it to our address listed above.

~~**Please read and sign this notice. Return it to us or mail it to our address listed above.**~~

Home Health Advance Beneficiary Notice (HHABN)

[Option Box 3 Sample]

We, _____ your home health agency, are letting you know that we _____ with the following items and/or services: _____

Because: _____

If you have questions about these changes, you can call us at (____) _____
TTY users should call (____) _____.

~~OMB Approval No. 0938-0781~~

~~Home Health Advance Beneficiary Notice~~

~~We, _____, your home health agency, are letting you know that we _____ with the following items and/or services: _____ _____ _____ _____ Because: _____ _____ _____ _____~~

~~If you have questions about these changes, you can call us at (____) _____
TTY users should call (____) _____.~~

By signing below, I understand that I received this notice because my doctor has changed my orders and so my home health plan of care is changing. This Home Health Agency has explained to me that they cannot provide home care without a doctor's order.

Patient's Name	~~Medicare # (HICN)~~Patient Identification
Signature of the Patient or of the Authorized Representative	Date

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Form No. CMS-R-296 (08/2012) OMB Approval No. 0938-0781

~~**Please read and sign this notice. Return it to us or mail it to our address listed above.**~~

~~Form No. CMS-R-296 (06/2006)~~ ~~*OPTION BOX 3*~~