SKILLED NURSING FACILITY ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (SNFABN)

Skilled Nursing Facility:	The Estates at Chateau - 612-874-1603 2106 2nd Avenue South Minneapolis, MN 55404

Beneficiary's Name:	Identification Number:

Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements.

Beginning on _____ , you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

Care: Inpatient stay at this Facility. Room and Board only.	Estimated Cost:
Reason Medicare May Not Pay: You don't require skilled care on a daily basis. Medicare won't pay for your stay at this facility unless you need daily skilled care for your medical condition.	

WHAT TO DO NOW:

- Read this notice to make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

Note: If you choose Option 1, we may help you use any other insurance that you may have, but Medicare can't require us to do this.

OPTIONS *(Check only one box. We can't choose a box for you).*:

☐ **Option 1:** I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN.

☐ **Option 2:** I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. **I cannot appeal because Medicare won't be billed.**

☐ **Option 3:** I don't want the care listed above. I understand that I'm not responsible for paying, and **I can't appeal to see if Medicare would pay.**

Additional Information:

____ Explained to resident that Option 3 indicates they do not want to continue to stay in this facility and are indicating preference to discharge. Explained/Offered Option 1 & 2 and informed resident if they do not discharge, they are responsible for paying for any applicable room and board charges if they do not have other insurance that may cover these costs.

Signing below means that you've received and understand this notice. You'll also get a copy for your records.

Signature of Patient or Authorized Representative*	**Date**

* If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call **1-800-MEDICARE** (1-800-633-4227) /**TTY**: 1-877-486-2048. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).