Medicaid, Private Insurance, & Private Pay

(Not to be used for Medicare Beneficiaries)

Bangs Ambulance Service, Inc
205 W. Green Street, Ithaca, N.Y. 14850 Phone: (607) 273-1161 Fax: (607) 277-9281

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)
YOU MAY BE RESPONSIBLE FOR PAYMENT

Read this notice so you can make an informed decision about the transport you are about to receive. Ask any questions you may have regarding this service prior to signing this form.

[ ] No insurance - I will be responsible for the full cost of the service provided.

[ ] The full cost of service is approximately $ _____

[ ] Medicaid – I understand you will not bill the Medicaid System on my behalf, and I will receive a bill for this service.

[ ] The full cost of service is approximately $ _____

[ ] Private Insurance - My insurance may not pay for this service, or they may pay for only a portion of the service. Listed below is the cost of the services which we estimate that insurance will not cover and that I may be responsible to pay.

[ ] The base rate for the transport - approximate cost $ _____

[ ] Full mileage _____ (Estimated # of miles) _____ (Cost per mile) $ _____

[ ] Only mileage beyond the closest facility able to treat you _____ (Estimated # of miles) _____ (Cost per mile) $ _____

[ ] Other services as listed below $ _____

_____

_____

_____

We will refund payment made to us if insurance pays for these services (less co-payments or deductibles).

After reviewing the above information I have chosen to have Bangs Ambulance transport me. I understand that Bangs will bill me for services not covered by insurance. I also understand that I may be asked to pay prior to transport, if not I agree to be personally and fully responsible for payment in full.

_____	_____	_____
Print Name	Signature of Patient	Date