DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Items and Services That Are Not Covered Under the Medicare Program

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This publication provides the following information:

- The four categories of items and services that are not covered under the Medicare Program and applicable exceptions to exclusions;
- The Advance Beneficiary Notice of Noncoverage (ABN); and
- Resources.

THE FOUR CATEGORIES OF ITEMS AND SERVICES THAT ARE NOT COVERED UNDER THE MEDICARE PROGRAM AND APPLICABLE EXCEPTIONS TO EXCLUSIONS

The following four categories of items and services that are not covered under the Medicare Program are discussed below:

1) Services and supplies that are not medically reasonable and necessary;
2) Excluded items and services;
3) Services and supplies that have been denied as bundled or included in the basic allowance of another service; and
4) Items and services reimbursable by other organizations or furnished without charge.

Where applicable, exceptions to exclusions are also included in this discussion.

1) Services and Supplies That Are Not Medically Reasonable and Necessary

Services and supplies that are not medically reasonable and necessary to the overall diagnosis and treatment of the beneficiary’s condition will not be covered. Some examples include:

- Services furnished in a hospital or Skilled Nursing Facility (SNF) that, based on the beneficiary’s condition, could have been furnished elsewhere (e.g., the beneficiary’s home or a nursing home);
- Hospital or SNF services that exceed Medicare length of stay limitations;
- Evaluation and management services that are in excess of those considered medically reasonable and necessary;
- Therapy or diagnostic procedures that are in excess of Medicare usage limits;
- Screening tests and examinations for which the beneficiary has no symptoms or documented conditions, with the exception of certain preventive screening tests and examinations as described below under Exceptions to Exclusion;
- Services not warranted based on the diagnosis of the beneficiary (e.g., biofeedback therapy, acupuncture, and transcendental meditation); and
- Items and services administered to a beneficiary for the purpose of causing or assisting in causing death (assisted suicide).
Services and supplies are considered medically necessary if they:

- Are proper and needed for the diagnosis or treatment of the beneficiary’s medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the beneficiary’s medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the beneficiary, provider, or supplier.

For every service billed, you must indicate the specific sign, symptom, or beneficiary complaint necessitating the service. Although furnishing a service or test may be considered good medical practice, Medicare generally prohibits payment for services without beneficiary symptoms or complaints.

**Exceptions to Exclusion**

The following preventive screening tests and examinations are covered when certain coverage requirements are met:

- Annual Wellness Visit;
- Initial Preventive Physical Examination (also known as the “Welcome to Medicare Visit”);
- Colorectal cancer screening;
- Screening mammography;
- Screening Pap tests;
- Screening pelvic examinations;
- Prostate cancer screening;
- Cardiovascular disease screenings;
- Diabetes screening tests;
- Glaucoma screening;
- Human Immunodeficiency Virus (HIV) screening;
- Bone mass measurements; and
- Ultrasound screening for abdominal aortic aneurysm.

Items and services that are administered for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, will be covered provided they are not furnished for the specific purpose of causing death.

2) **Excluded Items and Services**

**A) Items and Services Furnished Outside the U.S.**

Most items and services that are furnished or delivered outside the U.S. will not be covered, including when the beneficiary was within the U.S. when the contract to purchase the item was made or the item was purchased from an American firm. Payment will not be made for a medical service (or a portion thereof) that was subcontracted to another provider or supplier located outside the U.S.

Medicare pays for provider professional services that are furnished in the U.S. The Centers for Medicare & Medicaid Services (CMS) recognizes the 50 States, the District of Columbia, Commonwealth of Puerto Rico, Virgin Islands, Guam, Northern Mariana Islands, American Samoa, and territorial waters adjoining
the land areas of the U.S. (for services furnished onboard a ship) as being within the U.S. A hospital is considered outside the U.S. if it is not physically located in one of these jurisdictions, even if it is owned or operated by the U.S. Government.

Exceptions to Exclusion

Exceptions to this exclusion include the following:

- Emergency inpatient hospital services when the emergency occurs:
  - While the beneficiary is physically present in the U.S.; or
  - While the beneficiary is traveling in Canada provided the services are furnished without reasonable delay and the hospital is reached by the most direct route between Alaska and another State;

- Emergency or nonemergency inpatient hospital services furnished by a hospital located outside the U.S. provided the hospital is closer to or substantially more accessible from the beneficiary’s U.S. residence than the nearest participating U.S. hospital that is adequately equipped to deal with and available to treat the illness or injury;

- Physician and ambulance services furnished in connection with a covered foreign hospitalization (payment will not be made for any other Part B outpatient, medical, and other health services that are furnished outside the U.S.);

- Services furnished onboard a ship in a U.S. port or furnished within 6 hours of when the ship arrived at or departed from a U.S. port. Services that do not meet this requirement are considered furnished outside U.S. territorial waters, even if the ship is of U.S. registry;

- Physician and ambulance services furnished in Canada and covered by the Railroad Retirement Board to a railroad retirement beneficiary in connection with covered hospital services; and

- Services for a beneficiary who has elected religious nonmedical health care status (when this status is elected, the religious nonmedical health care institution election will be revoked).

B) Items and Services Required as a Result of War

Items and services that are required as a result of war or an act of war and that occur after the effective date of the beneficiary’s current entitlement date are not covered.
C) Personal Comfort Items and Services

Personal comfort items will not be covered as these items do not meaningfully contribute to the treatment of a beneficiary’s illness or injury or the functioning of a malformed body member. Some examples of personal comfort items are:

- Radios;
- Televisions; and
- Beauty and barber services, except as described below under Exceptions to Exclusion.

When a beneficiary requests a personal comfort item, you should inform him or her that there is a specified charge for the item. The specified charge may not exceed the customary charge, and future charges may not be more than the amount specified. The beneficiary cannot be required to request non-covered items or services as a condition of admission or continued stay.

Exceptions to Exclusion

Exceptions to this exclusion are basic personal services that residents in SNFs, general psychiatric hospitals, and tuberculosis hospitals need and cannot perform for themselves such as:

- Shaves;
- Haircuts;
- Shampoos; and
- Simple hair sets.

These services may be considered ordinary patient care and are covered costs reimbursable under Part A when they are:

- Furnished by a long-stay institution;
- Included in the flat rate charge; and
- Routinely furnished without charge to the beneficiary.

D) Routine Services and Appliances

The following routine services and appliances are not covered:

- Routine or annual physical checkups, except as described in the Exceptions to Exclusion Section under 1) Services and Supplies That Are Not Medically Reasonable and Necessary on page 2 of this booklet;
- Physical examinations that are performed without a specific sign, symptom, or beneficiary complaint necessitating the service or that are required by third parties (e.g., insurance companies, business establishments, or Government agencies);
- Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses;
- Eye refractions furnished by all practitioners for any purpose;
• Eyeglasses and contact lenses;
• Examinations for hearing aids;
• Hearing aids; and
• Immunizations.

Exceptions to Exclusion

Exceptions to this exclusion include:

• Physician services performed in conjunction with an eye disease (e.g., glaucoma and cataracts);
• Services performed incident to physician services in conjunction with an eye disease;
• Vaccinations directly related to the treatment of an injury or direct exposure to a disease or condition (e.g., antirabies treatment and immune globulin);
• Vaccinations that are specifically covered by statute (e.g., seasonal influenza virus, pneumococcal, and Hepatitis B);
• A reasonable supply of antigens (i.e., not more than a 12-week supply that has been prepared for a particular beneficiary) that a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) has prepared after examining the beneficiary and determining a plan of treatment and dosage regimen. A different physician may administer the antigens; and
• Certain devices that produce perception of sound by replacing the function of the middle ear, cochlea, or auditory nerve and are indicated only when hearing aids are medically inappropriate or cannot be utilized due to:
  ◦ Congenital malformations;
  ◦ Chronic disease;
  ◦ Severe sensorineural hearing loss; or
  ◦ Surgery.

These devices, which are payable as prosthetic devices, include:

• Cochlear implants and auditory brainstem implants that replace the function of cochlear structures or the auditory nerve and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays; and
• Osseointegrated implants that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer.
E) Custodial Care

Custodial care furnished in the beneficiary’s home or a SNF is not covered. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel and serves to assist an individual in the activities of daily living. The following activities are considered custodial care:

- Walking;
- Getting in and out of bed;
- Bathing;
- Dressing;
- Feeding;
- Using the toilet;
- Preparing a special diet; and
- Supervising the administration of medication that can usually be self administered.

Exceptions to Exclusion

Some reasonable and necessary services may be covered under Part A when a beneficiary’s hospital or SNF stay is determined to be custodial.

Care furnished to a beneficiary who has elected the hospice care option is considered custodial only if it is not reasonable and necessary for the palliation or management of the terminal illness and related conditions.

F) Cosmetic Surgery

Cosmetic surgery and expenses incurred in connection with cosmetic surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving the beneficiary’s appearance.

Exceptions to Exclusion

Exceptions to this exclusion include the prompt (i.e., as soon as medically feasible) repair of an accidental injury or the improvement of the functioning of a malformed body member. Some examples include:

- Surgery performed in connection with the treatment of severe burns;
- Surgery to repair the face following a serious automobile accident; and
- Surgery for therapeutic purposes that may coincidentally also serve some cosmetic purpose.
G) Items and Services Furnished by the Beneficiary’s Immediate Relatives and Members of the Beneficiary’s Household

Payment for items and services furnished by the beneficiary’s immediate relatives and members of the beneficiary’s household will not be made as these items and services are ordinarily furnished gratuitously because of the relationship between the beneficiary and the provider or supplier.

The following items and services will also not be paid:

- Charges for services furnished by a related physician or supplier that are submitted by an unrelated individual, partnership, or professional corporation; and
- Items and services furnished incident to a physician’s professional service when the ordering or supervising physician has an excluded relationship to the beneficiary.

A professional corporation is:

- Completely owned by one or more physicians or is owned by other health care professionals as authorized by State law; and
- Operated for the purpose of conducting the practice of medicine, osteopathy, dentistry, podiatry, optometry, or chiropractic.

Any physician or group of physicians that is incorporated constitutes a professional corporation. Items and services furnished by non-physician suppliers that have an excluded relationship with the beneficiary and are not incorporated will not be paid, regardless of whether the supplier is owned by a sole proprietor who is related to the beneficiary or owned by a partnership in which one of the partners is related to the beneficiary. This exclusion applies only to professional corporations, regardless of the beneficiary’s relationship to any of the stockholders, officers, or directors of the corporation or to the individual who furnished the service.

A beneficiary’s immediate relatives include the following degrees of relationship:

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- Grandparent and grandchild; and
- Spouse of grandparent or grandchild.
If the marriage upon which a step- or in-law relationship is terminated through divorce or death, the excluded relationship will continue to exist.

Members of the beneficiary’s household include the following who share a common abode with him or her as part of a single family unit:

- Individuals who are related by blood, marriage, or adoption;
- Domestic employees; and
- Other individuals who live together as part of a single family unit (does not include roomers or boarders).

H) Dental Services

Items and services that are furnished in connection with the care, treatment, filling, removal, or replacement of teeth or the structures directly supporting the teeth are not covered. The structures that directly support the teeth are the periodontium, which includes:

- The gingivae;
- The dentogingival junction;
- The periodontal membrane;
- The cementum; and
- The alveolar process.

Whether or not the beneficiary is hospitalized has no direct bearing on if payment will be made for a given dental procedure.

Exceptions to Exclusion

Some dental services are covered depending upon whether the primary procedure that the dentist performs is covered. For example, the following services are covered:

- An x-ray that is taken in connection with the reduction of a fracture of the jaw or facial bone; and
- A tooth extraction that is performed to prepare the jaw for radiation treatments of neoplastic disease.

I) Non-Physician Services Furnished to Hospital and Skilled Nursing Facility Inpatients That Are Not Provided Directly or Under Arrangement

In general, non-physician services furnished to Part A and Part B hospital inpatients and Part A SNF inpatients that are not provided directly or under arrangement are not covered.

Exceptions to Exclusion

Exceptions to this exclusion include the following:

- Physicians’ services furnished to hospital and SNF inpatients (with the exception of therapy, which must be provided by the SNF);
- Physician assistant services;
- Nurse practitioner services;
- Clinical nurse specialist services;
- Certified nurse-midwife services;
- Qualified clinical psychologist services; and
- Certified registered nurse anesthetist services.
The following Part A SNF inpatient services may be covered if they are not provided directly or under arrangement and are furnished by an authorized provider or supplier:

- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (including related necessary ambulance services);
- Epoetin Alfa (EPO);
- Hospice care related to a beneficiary’s terminal condition;
- Radioisotope services;
- Some customized prosthetic devices;
- Some chemotherapy and chemotherapy administration services;
- Services considered beyond the scope of a SNF when furnished in a participating hospital or Critical Access Hospital, including ambulance services related to such services (does not apply to services furnished in an Ambulatory Surgical Center);
- Cardiac catheterization;
- Computerized Axial Tomography scans;
- Magnetic Resonance Imaging;
- Ambulatory surgery that involves the use of an operating room;
- Radiation therapy; and
- Emergency services.

J) Certain Foot Care Services and Supportive Devices for the Feet

The following foot care services and devices are generally excluded from coverage, except as described below under Exceptions to Exclusion:

- Treatment of flat foot;
- Routine foot care, which includes:
  - The cutting or removal of corns and calluses;
  - The trimming, cutting, clipping, or debriding of nails; and
  - Other hygienic and preventive maintenance care (e.g., cleaning and soaking the feet, use of skin creams to maintain skin tone of either ambulatory or bedridden patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot); and
  - Orthopedic shoes and other supportive devices for the feet.
Exceptions to Exclusion

Exceptions to this exclusion include these devices and services:

- Orthopedic shoes that are an integral part of a leg brace;
- Therapeutic shoes furnished to diabetics;
- Services that are a necessary and integral part of an otherwise covered service (e.g., the diagnosis and treatment of ulcers, wounds, or infections);
- Treatment of warts on the foot (including plantar warts);
- Treatment of mycotic nails as follows:
  - For an ambulatory beneficiary, the physician attending the mycotic condition must document that:
    - There is clinical evidence of mycosis of the toenail; and
    - The beneficiary has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and
  - For a nonambulatory beneficiary, the physician attending the beneficiary’s mycotic condition must document that:
    - There is clinical evidence of mycosis of the toenail; and

- The beneficiary suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

- Presence of a systemic condition such as one of the following metabolic, neurologic, and peripheral vascular diseases (this is not intended to be a comprehensive list):
  - Diabetes mellitus;*
  - Arteriosclerosis obliterans;
  - Buerger’s disease;
  - Chronic thrombophlebitis;*
  - Peripheral neuropathies that involve the feet:
    - Associated with malnutrition and vitamin deficiency:*  
      - Malnutrition (general, pellagra);
      - Alcoholism;
      - Malabsorption (celiac disease, tropical sprue); and
      - Pernicious anemia;
    - Associated with carcinoma;*
    - Associated with diabetes mellitus;*
    - Associated with drugs and toxins;*
    - Associated with multiple sclerosis;*
    - Associated with uremia (chronic renal disease);*
    - Associated with traumatic injury;
Associated with leprosy or neurosyphilis; and
Associated with hereditary disorders:
  ▪ Hereditary sensory radicular neuropathy;
  ▪ Angiokeratoma corporis diffusum (Fabry’s); and
  ▪ Amyloid neuropathy.

*Routine procedures for these conditions are covered only if the beneficiary is under the active care of a M.D. or a D.O. and the physician has documented the condition.

Category B devices may be covered if they are considered medically reasonable and necessary and all other applicable Medicare coverage requirements are met.

L) Services Related to and Required as a Result of Services That Are Not Covered

Medical and hospital services that are related to and required as a result of services that are not covered as not medically reasonable and necessary or excluded from coverage will not be paid. Some examples of these services are:

- Cosmetic surgery;
- Non-covered organ transplants; and
- Services related to follow-up care or complications that require treatment during a hospital stay in which a non-covered service is performed.

Exceptions to Exclusion

When a beneficiary is hospitalized for a non-covered service and requires services that are not related to the non-covered service, the unrelated services will be covered. For example, if a beneficiary breaks a leg while he or she is in the hospital for a non-covered service, the services to treat the broken leg will be covered since they are not related to the non-covered service.

When a beneficiary is discharged from a hospital stay in which he or she receives non-covered...
services and subsequently requires services to treat a condition or complication that arose as a result of the non-covered services, reasonable and necessary medical or hospital services may be covered. Some examples include:

- The reversal of intestinal bypass surgery for obesity;
- Repair of complications after transsexual or cosmetic surgery; and
- Treatment of an infection at the surgical site of a non-covered service.

Any subsequent services that could be incorporated into a global fee are considered to have been paid in the global fee and will not be paid again.

3) Services and Supplies That Have Been Denied as Bundled or Included in the Basic Allowance of Another Service

The following services and supplies that have been denied as bundled or included in the basic allowance of another service will not be paid:

- Fragmented services included in the basic allowance of the initial service;
- Prolonged care (indirect);
- Physician standby services;
- Case management services (e.g., telephone calls to and from the beneficiary); and
- Supplies included in the basic allowance of a procedure.

4) Items and Services Reimbursable by Other Organizations or Furnished Without Charge

A) Services Reimbursable Under Automobile, No-Fault, or Liability Insurance or Workers’ Compensation (the Medicare Secondary Payer [MSP] Program)

Payment will not be made for items and services when payment has been made or can reasonably be expected to be paid promptly under:

- Automobile insurance;
- No-fault insurance;
- Liability insurance; or
- Workers’ Compensation (WC) law or plan of the U.S. or a State.
Exceptions to Exclusion

Medicare may make payment if the primary payer denies the claim and documentation is provided indicating that the claim has been denied in the following situations:

- The Group Health Plan denies payment for services because:
  - The beneficiary is not covered by the health plan;
  - Benefits under the plan are exhausted for particular services;
  - The services are not covered under the plan;
  - A deductible applies; or
  - The beneficiary is not entitled to benefits;
- The no-fault or liability insurer denies payment or does not pay the bill because benefits have been exhausted;
- The WC Plan denies payment (e.g., when it is not required to pay for certain medical conditions); or
- The Federal Black Lung Program does not pay the bill.

In liability, no-fault, or WC situations, a conditional payment for covered services may be made to prevent beneficiary financial hardship when:

- The claim is not expected to be paid promptly;
- A properly submitted claim was denied in whole or in part; or
- A proper claim has not been filed with the primary insurer due to the beneficiary’s physical or mental incapacity.

A conditional payment is made on the condition that the insurer and/or the beneficiary will reimburse Medicare to the extent that payment is subsequently made by the insurer.

B) Items and Services Authorized or Paid For by a Government Entity

In general, payment will not be made for the following items and services authorized or paid for by a government entity:

- Those that are furnished by a government or nongovernment provider or other individual at public expense pursuant to an authorization issued by a Federal agency (e.g., Veterans Administration authorized services);
• Those that are furnished by a Federal provider or agency that generally provides services to the public as a community institution or agency (hospitals, SNFs, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities are not included in this category). Federal hospitals, like other nonparticipating hospitals, may be paid for emergency inpatient and outpatient hospital services;
• Those that a Federal, State, or local government entity directly or indirectly pays for or furnishes without expectation of payment from any source and without regard to the individual’s ability to pay; and
• Those that a nongovernment provider or supplier furnishes and the charges are paid for by a government program other than Medicare or where the provider or supplier intends to look to another government program for payment (unless the payment by the other program is limited to Medicare deductible and coinsurance amounts).

C) Items and Services for Which the Beneficiary, Another Individual, or An Organization Has No Legal Obligation to Pay For or Furnish

Payment will not be made when the beneficiary, another individual, or an organization has no legal obligation to pay for or furnish the items or services. Some examples include:

• X-rays or immunizations that are gratuitously furnished to the beneficiary without regard to his or her ability to pay and without expectation of payment from any source; and
• An ambulance transport that is provided by a volunteer ambulance company. If the ambulance company asks but does not require a donation from the beneficiary to help offset the cost of the service, there is no enforceable legal obligation for the beneficiary or any other individual to pay for the service.

When items or services are furnished without charge to indigent Medicare beneficiaries and non-Medicare indigent patients because of their inability to pay, both groups must be billed consistently.
D) Defective Equipment or Medical Devices Covered Under Warranty

No payment will be made under cost reimbursement for defective medical equipment or medical devices under warranty if they are replaced free of charge by the warrantor or if an acceptable replacement could have been obtained free of charge under the warranty, but it was purchased instead.

Exceptions to Exclusion

When defective equipment or medical devices are replaced under warranty, hospital or other provider services that are furnished by parties other than the warrantor are covered despite the warrantor’s liability.

Payment may be made for defective equipment or medical devices as follows:

- When a replacement from another manufacturer is substituted because the replacement offered under the warranty is not acceptable to the beneficiary or to the beneficiary’s physician;
- Partial payment, if defective equipment or medical devices are supplied by the warrantor and a charge or a pro rata payment is imposed; and
- Payment is limited to the amount that would have been paid under the warranty if an acceptable replacement could have been purchased at a reduced price under a warranty, but the full price was paid to the original manufacturer or a new replacement was purchased from a different manufacturer or other source.
THE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE

Form CMS-R-131, the Advance Beneficiary Notice of Noncoverage (ABN), is a written notice that a Medicare Fee-For-Service Provider or supplier must give to a beneficiary before providing items or services that are usually covered by Medicare, but are not expected to be paid in a specific instance (e.g., lack of medical necessity). Providing an ABN allows the beneficiary to make an informed decision about whether to receive the item or service in question. Except for items and services that are always excluded from coverage, if a provider or supplier does not provide the beneficiary with an ABN when required, the beneficiary cannot be held financially liable for the items or services if Medicare payment is denied or reduced. If the provider or supplier properly notifies the beneficiary that the items or services may not be covered, he or she may seek payment from the beneficiary. Issuance of an ABN is not required prior to providing items or services that are always excluded from coverage; however, providers and suppliers may choose to issue a voluntary ABN as a courtesy to the beneficiary to alert him or her about forthcoming financial liability. Providers and suppliers who furnish items or services to the beneficiary based on the referral or order of another provider or supplier are responsible for notifying the beneficiary that the services may not be covered by Medicare and that he or she can be held financially liable for the items or services if payment is denied or reduced. A copy of the ABN should be kept in the beneficiary’s medical record.

### Advance Beneficiary Notice of Noncoverage (ABN)

**A. Notifier:**

**B. Patient Name:**

**C. Identification Number:**

**NOTE:** If Medicare doesn’t pay for D. ____________ below, you may have to pay. Medicare 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 may not pay for the D. ____________ below.

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RESOURCES

The following resources are available about the topics discussed in this publication:

• To find additional information about Medicare-covered services and the services that are not covered by Medicare, refer to Chapters 1, 6, 8, 9, 15, and 16 of the “Medicare Benefit Policy Manual” (Publication 100-02) and the “Medicare National Coverage (NCD) Determinations Manual” (Publication 100-03) located at http://www.cms.gov/Manuals/IOM/list.asp on the CMS website;

• To find additional information about MSP, refer to the “Medicare Secondary Payer Manual” (Publication 100-05) located at http://www.cms.gov/Manuals/IOM/list.asp on the CMS website;

• To find additional information about claims processing procedures for non-covered services, refer to the “Medicare Claims Processing Manual” (Publication 100-04) at http://www.cms.gov/Manuals/IOM/list.asp on the CMS website;

• To find additional information about preventive services, visit http://www.cms.gov/PreventionGenInfo and refer to Chapter 15 of the “Medicare Benefit Policy Manual” (Publication 100-02) located at http://www.cms.gov/Manuals/IOM/list.asp on the CMS website;

• To find additional information about the ABN, visit http://www.cms.gov/BNI/01_overview.asp on the CMS website; and

• To find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit http://www.medicare.gov on the CMS website.
The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at http://www.cms.gov/MLNGenInfo on the CMS website.