

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Medicare Number: [Insert Medicare Number]

Subject: Notice of Excluded Medicare Benefits

Dear [Insert Patient Name],

The purpose of this letter is to inform you that the service(s) listed below are generally not covered by Medicare. This is a voluntary notice provided to help you understand your potential financial responsibility.

Service/Item Description: [Insert Description of Service or Item]

Estimated Cost: \$[Insert Estimated Amount]

Reason for Non-Coverage:

- This service is excluded by law as it is not considered a "medical benefit" under the Medicare program (e.g., cosmetic surgery, routine hearing exams, long-term care).
- This specific item or service does not meet the definition of a Medicare benefit.

Because this service is a statutory exclusion, Medicare will not pay for it. If you choose to receive this service, you will be responsible for the full cost. This notice is not an official "Advance Beneficiary Notice of Noncoverage" (ABN), but is intended for your information.

If you have any questions regarding this notice, please contact our office at [Insert Phone Number]. You may also call 1-800-MEDICARE for general coverage information.

Sincerely,

[Provider/Facility Name]

[Provider Signature/Representative Name]

[Address]

[Phone Number]

Patient Acknowledgement:

By signing below, I acknowledge that I have been informed that the service(s) listed above are not covered by Medicare and that I am financially responsible for the cost.

Signature: _____ Date: _____