Instructions for the Revised Home Health Advance Beneficiary Notice (HHABN)
(Notice Approved January 2006)

I. Overview

Previously, home health agencies (HHAs) have issued HHABNs related to the absence or cessation of Medicare coverage only when a beneficiary had liability protection under §1879 of the Social Security Act (the Act). Consistent with these instructions, HHAs must now issue HHABNs in a broader set of circumstances in conjunction with their responsibilities under the home health Conditions of Participation (COPs). These instructions explain when the newly revised HHABN should be issued, take into account related changes associated with the expedited determination process implemented in 2005, and include additional changes to simplify notice policy for HHAs. (Expedited determinations allow beneficiaries to obtain an expedited review by a Quality Improvement Organization (QIO) in response to the termination of covered care by certain providers, including HHAs.) For HHAs, this generally means:

- HHABNs will be issued more frequently, although we do not anticipate any growth in claims related to HHABNs (such claims make up less than 4 percent of national home health claims annually based on our most recent available data).

- HHABNs will be given when Medicare coverage is not at issue, and different language will be used in the HHABN based on whether coverage is at issue.

- HHABNs will now be required more broadly for noncovered care, such as in situations where qualifying requirements for Medicare home health care benefits may not be met, such as having physician orders or being homebound.

- HHABNs still only afford liability protection based on section 1879 of the Act, so no impact is expected on decisions on liability for denials on claims related to HHABNs.

- HHABNs will be the single liability notice used for beneficiaries under Original Medicare: thus, HHAs need no longer use other comparable notices, as explained below.

II. Scope and Time Frame of Instructions

A. Notices

The revised HHABN has a form approval date of "01/2006" in its lower left hand corner. The new form, and the instructions for its use that are provided here, will be available on the CMS website used for such notices, under a dedicated link on the top left-hand margin: FFS HHABN. Note that the address of this web page recently changed to:

www.cms.hhs.gov/BNI/

Regional Home Health Intermediaries (RHHIs) must post the same information on their websites and alert HHAs under their jurisdiction to this posting via listserv. The previous HHABN (dated June 2002 on the bottom of that notice) will remain posted on the CMS website as well through May 31, 2006, after which it may no longer be used (see below).

The revised HHABN approved 01/2006 makes the use of other liability-related notices unnecessary. Thus, HHAs will no longer need to use:

- The general ABN (CMS-R-131) for Part B non-covered items/services outside the home health benefit.
- The voluntary notices, Notice of Exclusion from Medicare Benefits (NEMB) or the NEMB-Home Health Agency (NEMB-HHA), for noncovered care outside the definition of a Medicare benefit.

B. Transition to the Revised HHABN

After being notified of the release of the revised HHABN and instructions by their RHHI, HHAs will have 90 days to switch completely from the former HHABN to the new notice. We urge HHAs to begin using the new notice as soon as possible, given that the former HHABN does not include appropriate language for all situations now addressed by the revised HHABN, such as that in Option Box 2 (see section VI below).

C. Instructions

In the past, HHAs obtained the HHABN notice from the CMS website and found instructions for its use in the on-line Medicare Claims Processing Manual, Chapter 30, on Financial Liability Protections, which is referred to as Chapter 30 in the rest of this document. HHAs should still follow these instructions when using the June 2002 HHABN. **However, when using the revised HHABN, HHAs should follow the instructions in this document instead of the following parts of Section 60 of Chapter 30:**

Sections of Chapter 30 that are obsolete for the revised HHABN:

- 50.8.2 - ABNs for Medical and Other Health Services Furnished by a Home Health Agency (HHA) Under Part B
- 60.1 - Basic Requirements for HHABNs
- 60.1.2 - User-Customizable Section
- 60.1.3 - Where to Obtain the HHABN Forms
- 60.2.2.1 - Categorical Exclusions
- 60.2.2.2 - Technical Exclusions
- 60.2.2.3 - Services Not Under HHA PPS
- 60.2.3.1 - Triggering Events
- 60.2.3.2 - Dual-Eligibles
- 60.3.2 - HHABN Specific Delivery Issues
- 60.4 - Form Instructions for the HHABN (Form CMS-R-296)
- 60.4.1 - General Rules

- 60.4.2 - Header of HHABN
- 60.4.3 - Body of HHABN
- 60.4.4 - Option Boxes
- 60.6.6 - Home Care Not Ordered by Physicians

Home health instructions/examples in the following sections are obsolete for the revised HHABN:

- 90 - Form CMS-20007 - Notices of Exclusions From Medicare Benefits (NEMBs)
- 90.1.1 - Using NEMBs With Categorical Denials
- 90.1.2 - Using NEMBs With Technical Denials

Instructions to use the NEMB are obsolete in:

- Chapter 10, Home Health Agency Billing (in the same manual as Chapter 30), §50.

Instead, the revised HHABN would be used.

D. Applicability

As before, financial liability protection (FLP) notices like the HHABN continue to be used solely for individuals enrolled in Original or Fee-For-Service (FFS) Medicare, as §1879 applies only to Parts A and/or B of the Program. If a beneficiary is eligible for both Medicare FFS and Medicaid (a dual eligible), or Medicare FFS and another insurance program, and a triggering event occurs (see section III below), the HHA still needs to give the beneficiary a HHABN.

NOTE: In the following instructions, the term "beneficiary" includes either the beneficiary or the beneficiary's authorized representative, as applicable. Therefore, these instructions apply whether the HHA gives the HHABN to a beneficiary or an authorized representative. For more information on authorized representatives, see Chapter 30, §40.3.5.

HHAs should contact their RHHIs if they have questions on the revised HHABN or the related instructions developed by CMS, since RHHIs administer home health and hospice benefits for Original Medicare.

E. Limitation of Liability (LOL)

Historically, CMS advised that HHAs were required to issue HHABNs only in those specific situations where LOL protection is afforded under section1879 for items(s) and/or service(s) ordered by physicians that the HHA believed Medicare would not cover. **The HHABN is still required in these situations for the anticipated denial reasons listed in following chart:**

Application of LOL for the Home Health Benefit

Citation from the Act	Brief Description of Situation	Explanation
§1862(a)(1)(A)	Care is not reasonable and necessary	Medicare does not pay for such care
§1862(a)(9)	Custodial care is the only care delivered	Medicare does not usually pay for such care, except for some hospice services
§1879(g)(1)(A)	Beneficiary is not homebound	Medicare requires that a beneficiary cannot leave home in order to cover services under the home health benefit
§1879(g)(1)(B)	Beneficiary does not need intermittent skilled nursing care	Medicare requires this need in order to cover services under the home health benefit

In addition, HHABNs must now be given in some situations where: (1) LOL protection is not available when a triggering event occurs, and (2) there is not any liability and a triggering event occurs. Thus, notices will be given when:

- The beneficiary will not be charged, and
- There is no liability because noncovered charges are part of an otherwise covered bundled payment.

III. HHABN Triggering Events

Generally, HHAs are required to issue HHABNs whenever they believe they are about to deliver noncovered item(s) and/or service(s) at three points in time called triggering events:

Definition of Triggering Events

EVENT	DESCRIPTION
A. Initiation	When a HHA expects that Medicare will not cover any item(s) and/or service(s) from the start of a spell of illness, or before the delivery of an one-time item or service that Medicare is not expected to cover.
B. Reduction	When a HHA reduces or stops some item(s) and/or service(s) during a spell of illness, while continuing others, whether or not the discontinued care had been covered by Medicare.
C. Termination	When a HHA ends delivery of all care, whether covered by Medicare or not.

Formerly, HHABNs were given only when triggering events occurred, either when only noncovered care started at admission, or when some or all covered care ended. Now as illustrated below, HHAs are required to issue the HHABN more frequently, particularly in situations involving care that the HHA believes Medicare clearly will not cover (and regardless of whether the care may be "necessary" in the HHA's or beneficiary's view).

In the context of triggering events and coverage, HHABNs are given as follows:

Relation of Triggering Events to Notice Delivery

TRIGGERING EVENT	NONCOVERED CARE	COVERED CARE
A. Initiation	HHABN	N/A
B. Reduction	HHABN	HHABN
C. Termination	HHABN	Generic Expedited Determination Notice [and sometimes HHABN*]

* The HHABN is given with the generic expedited determination notice when noncovered care will continue after the termination of covered care.

NOTE: This aspect of the notice delivery rules is unique to home health. HHAs that also operate hospices, other types of Medicare providers or suppliers should NOT assume these notice requirements are identical for triggering events when other types of care are involved.

A. Initiations

HHAs must always provide information on covered and noncovered charges at admission as required under the home health COPs. CMS does not mandate a standardized notice format to be used to provide this information.

Noncovered Care. The HHABN is given when initiating noncovered care that fits one of the following scenarios:

- **Not a Medicare Benefit.** The HHA concludes that the item(s) and/or service(s) do not meet the definition of a Medicare covered benefit defined in Title XVIII (Medicare) of the Act. LOL protection never applies.

- **Excluded from Coverage under §1862.** The HHA concludes that the item(s) and/or service(s) fall within specific statutory exclusions listed in §1862(a)(2)-(8) or (10)-(22) of the Act, e.g., the item or service is a personal comfort item or routine foot care. LOL protection never applies.

- **Excluded from Coverage and Subject to Limitation of Liability (LOL) under §1879.** The HHA concludes that one of the situations listed in the table in II. above entitled "Application of LOL for the Home Health Benefit" applies.

For initiations, also note:

- The HHABN, not the NEMB or NEMB-HHA, should now be used if HHAs plan to charge beneficiaries for an assessment that is not followed-up by an admission, in accordance with the home health COPs.

- Notice would have to be given for termination of covered care before the initiation of solely noncovered care.

B. Reductions

Reductions and terminations are sometimes confused, but in the case of reductions, the HHAs must be discontinuing some, not all, care, whether the care ending or the continuing care is covered by Medicare or not. Reductions may include cases where one type of care ends but other type(s) continue, such as the end of skilled nursing with the continuation of therapy.

Noncovered Care. A HHABN is given when there is a reduction in previously noncovered care, under the scenarios listed above under **A. Initiations**. Note that for reductions:

- The most likely reason noncovered care would be reduced is that it is no longer reasonable or necessary, but there is no LOL protection in this case because care is already noncovered.

- A HHABN should also have been given at initiation if all care from initiation was noncovered.

Covered or Noncovered Care. A HHABN is also given when some care, either covered or noncovered, ends because of:

- **Financial/Other HHA Reasons.** The HHA has reasons individual to its business and independent of the beneficiary's Medicare coverage for discontinuing some item(s) and/or service(s). Note LOL protection does not apply in this case.

    - As above, HHABNs should also have been given at initiation if all subsequent care was noncovered.

Covered Care. A HHABN is given when there is a reduction because some previously covered care becomes:

- **Excluded from Coverage and Subject to Limitation of Liability (LOL) under §1879.** See discussion of this scenario under **A. Initiation** above.

- Though unlikely given the services HHAs perform, a HHABN would also be required if covered care was being reduced because it was **Not (no longer) a Medicare Benefit,** such as if exceeding a statutory frequency limit**.** See this scenario under **A. Initiation** above.

Finally, note that there are certain, limited situations when a HHABN is not required, even though a reduction occurs. See section IV below.

C. Terminations

Termination is the complete cessation of all item(s) and/or service(s) at the end of a course of treatment, as opposed to reductions, where only some care ends.

Noncovered Care. HHAs must issue HHABNs prior to termination of completely noncovered care under the scenarios listed above under **A. Initiations**. For terminations, as with reductions:

- The most likely reason noncovered care would be terminated is that it is no longer reasonable or necessary, but there is no LOL protection in this case because care is already noncovered.

- When HHABNs are given for such terminations, a HHABN should have been given at the initiation of the noncovered care.

Covered or Noncovered Care. For terminations unrelated to Medicare coverage, of either covered or noncovered care, a HHABN must be issued for:

- **Financial/Other HHA Reasons.**

    - Such reasons could include the end of services due to loss of staff needed to supply all services under the home health benefit, because of safety issues at the beneficiary's home, closure of the HHA providing care, etc.; in short, where the beneficiary's coverage is not changed by the HHA decision to end care.

    - As with reductions done for this reason, LOL protection does not apply, and HHABNs should have been given at initiation if all subsequent care was noncovered.

Covered Care. For terminations for reasons related to coverage:

- **Expedited determination notice(s) are required** when all Medicare coverage is terminating.

    - Reasons for terminating coverage include when care is **Excluded from Coverage and Subject to Limitation of Liability (LOL) under §1879.** See the table entitled "Application of LOL for the Home Health Benefit" in II.

    NOTE: **There is only one case where both the HHABN and the generic expedited notice must be given, and that is ONLY if noncovered services will be continuing after covered services are ending.** That is because the notices address different things: the expedited notice gives information on the right to a quick decision from a QIO affirming or

disputing the end of all covered care. The HHABN provides information on potential liability for care that would be delivered after coverage ends, and on claim-related appeal rights. (Note instructions for expedited determinations and notices are in 2005 CMS transmittal 594 and the URL web address given above-- transmittals are also found on the CMS website.)

Finally, note that there are certain, limited situations when a HHABN is not required, even though a service termination occurs. See section IV below.

IV. Exceptions to HHABN Notification Requirements

Under some very limited circumstances, HHABNs are not mandatory, despite the occurrence of a triggering event. Examples of these kinds of situations are listed below, as well as an indication of whether the exception in question is linked to a specific triggering event.

Table of Exceptions to HHABN Notification Requirements

EXCEPTION	APPLICATION	COMMENT
Increases in Care	General	Any increases whether under the original plan of care (POC) or subsequent orders.
Transfers	General	Transfers to other covered care, i.e. another home health agency or another type of Medicare provider.
Shortening the Duration of Care	Reductions	Any change in the duration of services included in the POC and communicated to the beneficiary, i.e., shorter therapy sessions, perhaps going from an hour to 45 minutes, as health status improves.
Planned Reductions in the Number of Services	Reductions	Only applicable when reductions anticipated in the POC are communicated to the beneficiary in advance/at admission, i.e., physical therapy provided three times a week for the first 2 weeks, and then reduced to two times a week.
Patient Goals Met	Terminations	All care ending with patient goals met and/or physician orders completed. (**Note that an expedited determination notice must be given in this case**).
Beneficiary Choice	Reduction or Termination	Changes in care that are the beneficiary's decision and are documented in the medical record.
Emergency or Unplanned Situations	General	Emergencies or unplanned situations beyond the HHA's control, i.e., natural disasters or transportation failures.
Changes in Caregiver or Personnel	General	Any changes in HHA caregivers or personnel

EXCEPTION	APPLICATION	COMMENT
Changes in Brand	General	Any changes in expected arrival or departure time for HHA staff.
Changes in Brand	General	Any changes in brand of product, i.e. the same item produced by a different manufacturer.

V. General HHABN Requirements

The following are the general instructions HHAs must follow in preparing a HHABN:

A. Number of Copies: A minimum of two copies, including the original, must be made so the beneficiary and HHA each have one.

B. Reproduction: HHAs may reproduce the HHABN by using self-carbonizing paper, photocopying the HHABN, or other appropriate methods. All reproductions must conform to these instructions.

C. Length and Page Size: The HHABN must NOT exceed one page in length. The HHABN is designed as a letter-sized form. However, it may be expanded to a legal-sized page to accommodate information HHAs insert in the notice, e.g., the HHA's name, item(s) and/or service(s) that will no longer be provided, cost information.

D. Contrast of Paper and Print: A visually high-contrast combination of dark ink on a pale background must be used. Do not use reversed print (e.g., white on black), or block-shade (highlight) notice text.

E. Modification: The HHABN may not be modified, except as specifically allowed by these instructions.

F. Font: The HHABN must meet the following requirements in order to facilitate beneficiary understanding:

1. Font Type: To the greatest extent practicable, the fonts as they appear in the HHABN downloaded from the RHHI/CMS website should be used. Any changes in the font type should be based solely on software and/or hardware limitations of the HHA. The following are examples of easily readable alternative fonts:

- Arial,
- Arial Narrow,
- Times Roman, and
- Courier.

2. Font Effect/Style: Any changes to the font, such as italics, embossing, bold, etc., should not be used since they can make the HHABN more difficult to read.

3. Font Size: The font size must be at least 12 point (18 point for the title), except that insertions in blanks of the HHABN can be as small as 10 point if needed.

4. Insertions in Blanks: Information inserted by HHAs in the blank spaces on the HHABN may be typed or legibly hand-written.

VI. Completion of the HHABN

The HHABN approved 01/2006 is composed of four sections:

A. The Header Section,
B. The Body Section,
C. The Option Boxes, and
D. The Signature and Date Section.

Section D is completed by the beneficiary, and therefore is only discussed under VII. Beneficiary Completion, below.

The revised HHABN is a one-page notice. However, CMS releases the HHABN in a file that contains three pages. The first page is instructional and never distributed to beneficiaries. It has instructions for filling in the blanks and boxes in the notice. To differentiate the instructions from the actual notice text, the instructions are printed in a different font in addition to being placed in the appropriate blanks.

The next two pages are actual HHABNs ready for use. The second page is a HHABN with blanks unfilled, except Option Box 1 text is placed into the boxed area of the notice. This version looks most like the HHABN previously used by HHAs. The last page is also a HHABN with blanks unfilled, except Option Box 2 text is placed into the boxed area. The following instructions in this section explain how HHAs choose which option box/blank version is appropriate, and otherwise how to complete HHABNs prior to issuing them to beneficiaries.

A. The Header Section

HHAs are permitted to customize the header section of the HHABN. The header section is above the title of the notice, "Home Health Advance Beneficiary Notice," which appears in larger point font size at the top of the page.

After downloading the notice from the RHHI/CMS website, HHAs add identifying information, including HHA name, logo, and billing address. At minimum, information allowing the beneficiary to contact the HHA must appear, including the provider name and address (telephone number is given elsewhere on the notice).

B. The Body Section

The body section of the HHABN is below the header and above the option boxes. The HHA completes the following blanks in this section:

Step 1: In the sentence beginning "We,_____, your home health agency,. . .", the HHA adds its name in the blank space provided.

Step 2: In the next blank beginning "are letting you know that we_____", the HHA must add one of the following phrases:

A. Initiations of Noncovered Care. Insert the phrase:

"will not provide you (unless you select options 2 or 3 below)"

B. Reduction of Covered or Noncovered Care (except C. below). Insert the phrase,

"will no longer provide you (unless you select options 2 or 3 below)"

C. Reductions Based on Financial/Other HHA Reasons or Terminations. Insert the phrase:

"will no longer provide you ".

Regarding use of these phrases:

- HHABNs given with a generic expedited determination notice because noncovered care will continue after coverage ends would be considered initiations, not terminations.

- If unlikely cases occur where multiple triggering events occur simultaneously, separate HHABNs should be prepared for each triggering event.

Step 3: The HHA must then list on the blank lines immediately after "with the following items and/or services:" the item(s) and/or service(s) anticipated to be noncovered that are the reason for issuing the HHABN.

Step 4: After the word "Because:" the HHA must provide specific information regarding why the item(s) and/or service(s) listed are expected not to be covered by Medicare, or will no longer be provided by the HHA. If multiple item(s) and/or service(s) are listed by the HHA when completing Step 3, and different reasons exist for including each item or service on the HHABN, the HHA is responsible for providing sufficient information in Step 4 to allow the beneficiary to easily understand each reason specifically associated with each item or service listed.

Regarding the completion of Step 4:

- **The reasons provided must be in plain language and allow the beneficiary to fully understand the basis for the HHA's conclusion regarding probable noncoverage, thereby letting the beneficiary make an informed choice about accepting financial liability.** As examples, the information must convey more than simply that care is "not reasonable or necessary" or "not a Medicare benefit". If such conditions are thought to apply, state why they apply. The level of detail given should at minimum be similar to that found in a Medicare Summary Notice (MSN) message.

- If multiple item(s) and/or service(s) are listed by the HHA in Step 3, and there are different reasons for including these multiple things on the HHABN, the HHA is responsible for providing sufficient information in Step 4 to allow the beneficiary to understand the reasons associated with each item or service.

Step 5: In the paragraph beginning, "If you have questions . . .", the HHA must enter its own telephone number, and/or provide a TTY number for speech or hearing impaired beneficiaries, or include directions for using another telecommunication system for such individuals, when applicable.

C. The Options Boxes

One of the two "option boxes" is placed in the middle of the HHABN between the body and signature and date sections. **HHAs are required to determine the appropriate text (Option Box 1 or Option Box 2 below) to place in the blank option box based on the reason(s) listed in Step 4 of the Body Section. Note:**

- Option Box 2 is only appropriate when care is being reduced or terminated for a HHA's own financial and/or other reasons unrelated to the beneficiary's Medicare coverage, **Option Box 1 is used in all other cases.**

- If a situation occurs where both Option Box 1 and Option Box 2 apply, HHAs should prepare a separate HHABN for each, i.e., HHAs must not include both option boxes on a single notice.

1. Option Box 1

Option Box 1 is used more frequently. The insertion for Option Box 1 is in quotation marks below:

Option Box 1 Text

"The estimated cost of the items and/or services listed above is $_____. We think you have _____ insurance that may cover the items and/or services. However, you may have other insurance that we are not aware of.

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 an MSN for your claim, you can call Medicare at: (___) _____. TTY: (___) _____. 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 I chose the option above because they told me Medicare may not pay."

Step 1: The HHA must enter the total estimated cost of the item(s) and/or service(s) listed in the body section in the blank available in the first line of text in Option Box 1. Since one or multiple items and services could be at issue, the HHA must enter costs for each item or service, clarify the number of items or services, and include information on the period of time involved. For example:

"$400 for 4 weekly nursing visits in 1/06";

"$210 for 3 phys. therapy visits 1/3-17/06, $50 DME"
[the durable medical equipment [DME] should be named as space allows].

Note:

- The HHA must annotate the amount the beneficiary may have to pay if he/she later chooses to receive only certain item(s) and/or service(s) of those listed on the HHABN instead of everything originally listed.

- The estimated cost reported on the HHABN may be $0 if a HHA chooses not to charge a beneficiary, or if bundled payments with no beneficiary liability are involved.

Step 2: In the space provided in the second sentence of Option Box 1, the HHA must state whether another Federal insurance program of which the HHA is reasonably aware, such as Medicaid or Tricare, may cover the item(s) and/or service(s) at issue. If the HHA is not aware of any other coverage, this blank should be left empty.

Step 3: In the space provided in the "Please note:" section of Option Box 1, the HHA must provide the 1-800-MEDICARE phone number in the first blank and, in the second blank, and the TTY telephone number or directions for using Medicare's other telecommunication system for individuals with impaired speech or hearing, when applicable. If the HHA does not have the required TTY number, the HHA should call its RHHI and obtain it.

2. Option Box 2

Option Box 2 is used when the HHA decides to stop providing certain item(s) and/or service(s) for its own financial and/or other reasons, such as the availability of staffing, regardless of Medicare policy or coverage. There is no information to complete in Option Box 2. The insertion for Option Box 2 is (in quotation marks):

Option Box 2

> **"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."

VII. Beneficiary Completion of the HHABN

When delivering HHABNs to beneficiaries, HHAs are required to explain the notice and its content, and answer all beneficiary questions orally to the best of their ability. HHAs must make every effort to ensure beneficiaries understand the entire HHABN prior to signing it. Note in-person delivery is not required consistent with general ABN requirements, see Chapter 30, §40.3.4.1.

A. Option Box 1

The HHA must give oral directions to ensure the beneficiary selects only one of the 3 options available. The HHA must advise the beneficiary that if Option 3 is chosen, the beneficiary then must check under that option whether the claim should be submitted to Medicare, to the beneficiary's other insurer(s) listed in the blank provided, or to both. If the beneficiary changes

his/her mind as to the option selected after signing the notice but before care is delivered, the HHABN should be annotated with this change.

B. Option Box 2

There is no information in the option box for the beneficiary to complete. However, the HHA must tell the beneficiary orally that the HHA will no longer provide the item(s) and/or service(s) on the notice, noting that the beneficiary may obtain the same or similar care from another HHA, since his/her coverage through Medicare is not affected. HHAs are encouraged to do as much as possible to offer ideas for contacting another HHA , especially since the HHA still needs to try to assure its patient reaches the goals of the care plan even when discharging, and must inform the ordering physician consistent with the home health COPs.

C. The Signature and Date Section

Once the beneficiary has reviewed and understands the information contained in the HHABN, the HHA must request that the beneficiary complete all four blanks in the boxed Signature and Date Section at the bottom of the HHABN. The four blanks are:

- **Patient's Name:** The beneficiary's full name should be included in the blank.
- **Medicare # (HICN):** The beneficiary's Medicare health insurance claim number should be included in the blank.
- **Signature:** The beneficiary must personally sign the HHABN.
- **Date:** The beneficiary must personally enter the date on which the HHABN was received and completed.

NOTE: The HHA may complete the first two blanks to assist the beneficiary.

If the beneficiary refuses to sign the HHABN, the HHA must write that the beneficiary refused to sign on the HHABN itself, and provide a copy of the annotated HHABN to the beneficiary.

VIII. Copies and Retention of the HHABN

The HHA keeps the original version of the completed HHABN, whether annotated or signed, in the beneficiary's record. The beneficiary HHA receives a copy of the completed HHABN.