Advance Beneficiary Notice (ABN) Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

An Advance Beneficiary Notice (ABN), Form CMS-R-131, tells an Original Medicare patient before a specific service that Medicare is expected to deny payment, so they can choose whether to proceed and accept the cost. Issue the official CMS form (OMB 0938-0566); this sheet covers the entries that make it valid. Original Medicare FFS only, never Medicare Advantage, and never a blanket intake form.

Notifier and patient identification who is telling whom
Do: enter the practice name, address, and phone, and the patient's name; an internal chart number is optional.
Pitfall: the MBI and SSN must not appear anywhere; obsolete copied templates still show a "Medicare #" field.

Service expected to be denied specific, never a category
Do: name the particular service; for a course state frequency and duration; for a partial denial name the excess part.
Pitfall: "all therapy sessions" and blanket intake forms identify no expected denial and shift nothing.

Reason Medicare may not pay the case-specific basis
Do: write the actual expected coverage problem in plain language, one reason for each listed service.
Pitfall: generic wording ("Medicare may not pay") states no basis and fails the completion instructions.

Estimated cost good-faith, in writing
Do: enter a good-faith figure, per session and for the course; a high estimate is generally acceptable.
Pitfall: a blank cost field violates the instructions; exactness is not required, an entry is.

The three options the patient's choice
Do: explain the choices: bill Medicare (appeal rights kept), no Medicare claim (no appeal), or decline the service.
Pitfall: staff or software preselecting an option invalidates the notice outright.

Signature, date, and delivery before the service, with explanation
Do: have the patient or representative sign and date before the service; answer questions; give a copy every time.
Pitfall: after-the-session signatures shift nothing, and the clinician's signature is not required at all.

Claim and file the modifier must match the file
Do: report GA only when a valid signed notice is on file; retain it 5 years (longer if state law requires).
Pitfall: GA is not self-proving; the contractor can inspect the form and move liability back to the practice.

Before anyone signs

- ☐ Specific service, frequency, and duration stated
- ☐ Case-specific reason in plain language, never generic
- ☐ Good-faith estimate entered, never left blank
- ☐ No MBI or SSN anywhere on the form
- ☐ Option chosen by the patient, never preselected
- ☐ Signed and dated before the service; copy given

Drafting with AI

Bring the service and frequency, the coverage concern, and your fee; the form is fixed by CMS, the entries are what you draft.

"Draft ABN entries: second weekly 90834 session, 12 weeks from 08/10/2026, $145 per session, expected frequency denial: …"

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

One page	5 to 10 min by hand	Before the service	Patient · billing file
entries on the official CMS-R-131	clinical team estimate	when a specific denial is expected	and contractors on request

Full guide, sample notice, and compliance notes:
bastiongpt.com/template/abn-notice

BastionGPT drafts notice entries and checks them before signature. Free 7-day trial.

ABN Preparation Worksheet

Prepare entries for the official Form CMS-R-131 · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Patient name: | Internal ID (optional; never MBI or SSN): | Date prepared:

Practice name and address: | Practice phone:

Service expected to be denied

Specific item or service · frequency and duration for a course · the excess component for a partial denial

Reason Medicare may not pay

Plain language, case-specific, one reason for each listed service · no generic wording

Estimated cost

Good-faith figure · per session and course total · never leave blank

Options (the patient's choice; never preselect)

- ☐ Option 1: bill Medicare; the patient accepts responsibility if Medicare denies; Medicare appeal rights preserved.
- ☐ Option 2: no Medicare claim; the patient pays; no Medicare appeal for this service.
- ☐ Option 3: the patient declines the service.

If the patient refuses to sign or choose, annotate the refusal on the notice and date it.

Delivery and explanation

Reviewed with the patient · questions answered · copy given (date and how) · signature and date go on the official form, before the service

Claim and file note

GA only with a valid signed notice on file; GZ if none · retain 5 years, longer if state law requires · produce on contractor request

☐ GA (valid ABN on file) ☐ GZ (no valid ABN; provider write-off)

Prepared by (name / role): | Date:

Copy given to patient (date / how):