NEW MEXICO
Clinical Research &
Osteoporosis Center, Inc.

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Patient Name:_____ **Identification Number:**_____

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If Medicare doesn't pay for the service 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 service below.

Services to be Received	Reason Medicare May Not Pay	Estimated Cost:
☒ Bone Density Exam (DXA) ☐ Vertebral Fracture Assessment (VFA) ☐ Electrocardiogram (EKG) ☐ Injection _____ ☐ Infusion _____ ******Cost of injection & infusion includes the administration of the drug******	☐ Not payable within this time period. ☐ Service never paid due to medically unnecessary. ☐ Your diagnosis does not support the need for this service. ☐ This many services are usually not paid. ☒ Frequency Limitations for Coverage ☐ Other Reason _____ _____	☒ **Between $165 + tax** ☐ _____ ☐ _____ ☐ _____ ☐ _____

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the service (s) or item (s) listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the _____DXA_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the _____DXA_____ listed above, but do not bill Medicare. You may ask to be paid now, as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the _____DXA_____ listed above. I understand with this choice I am **not** responsible for payment**,** and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Accredited by the International Society for Clinical Densitometry for bone densitometry and vertebral fracture assessment

300 Oak St. NE, Albuquerque, NM 87106
Phone 505.855.5525 Fax 505.884.4006
www.nmbonecare.com

Bone Densitometry: Patient History Form

Revised 12/17

NEW MEXICO CLINICAL RESEARCH &OSTEOPOROSIS CENTER, INC.

Name:	DOB:	Date:
Address:	Home Phone:	Cell Phone:

Osteoporosis Risk Factor Assessment

	Yes	No
Are you a postmenopausal woman?	❒	❒
Have you lost more than 2 in. height?	❒	❒
Have you broken bones since age 40?	❒	❒
Does your mother or father have osteoporosis? ❒Mother ❒Father	❒	❒
Has your mother or father had a broken hip? ❒Mother ❒Father At what age?_____	❒	❒
Do you smoke cigarettes?	❒	❒
Have you ever taken steroids, such as prednisone, for more than 3 months?	❒	❒
Are you now taking prednisone?	❒	❒
Have you been on chemotherapy?	❒	❒
Do you have kidney disease? Nephrologist _____	❒	❒
Do you have rheumatoid arthritis? Rheumatologist_____	❒	❒
Do you take anticonvulsant medication, like Dilantin, phenobarb, or Tegretol?	❒	❒

	Yes	No
Do you have any thyroid problems? ❒hyper (overactive) ❒hypo (underactive) Endocrinologist_____	❒	❒
Do you have any parathyroid problems? ❒hyper (overactive) ❒hypo (underactive) Endocrinologist_____	❒	❒
Do you have a high calcium level in your blood?	❒	❒
Do you have inflammatory bowel disease, Crohn's disease, or ulcerative colitis?	❒	❒
Do you have malabsorption problems or celiac disease?	❒	❒
Have you had stomach surgery, such as gastrectomy or stapling?	❒	❒
Have you had anorexia?	❒	❒
Have you had bulimia?	❒	❒
Have you had an organ transplant?	❒	❒
Do you have a paralyzed arm or leg?	❒	❒
Do you have 3 or more alcohol drinks per day?	❒	❒

Do you currently take or have you ever taken the following medications?

		Dose	Date Started	Date Stopped	Reason Stopped
❒	Calcium			❒current	
❒	Calcium with Vitamin D			❒current	
❒	Multivitamin			❒current	
❒	Vitamin D			❒current	
❒	Estrogen ❒patch ❒pill ❒cream			❒current	
❒	Testosterone			❒current	
❒	Prednisone			❒current	
❒	Fosamax (alendronate)			❒current	
❒	Actonel, Atelvia (risedronate)			❒current	
❒	Evista (raloxifene)			❒current	
❒	Miacalcin, Fortical (calcitonin)			❒current	
❒	Forteo (teriparatide)			❒current	
❒	Boniva (ibandronate)			❒current	
❒	Reclast (zoledronic acid)			❒current	
❒	Prolia (denosumab)			❒current	
❒	Abaloparatide (tymlos)			❒current	
❒	Didronel (etidronate)			❒current	
❒	Strontium			❒current	

Please list all other medications you are currently taking. (Write none if none)

Bone Densitometry: Patient History Form

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NEW MEXICO CLINICAL RESEARCH &OSTEOPOROSIS CENTER, INC.

Name:	Date of Birth:	Today's date:

Have you ever broken or fractured a bone? ❒ Yes ❒ No

Which bone?	Age	What happened?
❒right ❒left		
❒right ❒left		
❒right ❒left		
❒right ❒left		

Do you exercise regularly? ❒ Yes ❒ No

Form of exercise	Frequency per week	Length of time per workout

What was your <u>height</u> at age 25? _____ <u>Weight</u> at age 25?_____

Gender Specific Risk Factors

<u>For women only:</u>

At what age was your **<u>LAST</u>** period? _____
How did menopause begin?
❒Natural ❒Hysterectomy
If you have ever had a hysterectomy, which describes your procedure?
❒Both ovaries were removed
❒One ovary still remains
❒Both ovaries still remain
Are you currently having irregular periods?
❒Yes ❒No
Has there been an episode when your period stopped for a significant amount of time?
❒Yes ❒No
Have you ever had phlebitis or blood clots?
❒Yes ❒No
Have you had breast cancer?
❒Yes ❒No
If yes- Date diagnosed _____
❒right ❒left
❒chemo ❒radiation ❒surgery
Have you ever taken or do you currently take Femara (letrozole), Arimidex (anastrazole), Aromasin (exemestane), or Tamoxifen?
❒Yes ❒No If yes, for how long? _____
Have you had cancer of the…
❒Ovary (❒right or ❒left) ❒Uterus ❒Cervix ❒None
If yes- Date diagnosed _____
❒chemo ❒radiation ❒surgery

<u>For men only:</u>

Do you have erectile dysfunction (impotence)?
❒Yes ❒No
Do you have low testosterone?
❒Yes ❒No
Have you had prostate cancer?
❒Yes ❒No
If yes- Date diagnosed _____
❒chemo ❒radiation ❒surgery
Are you currently receiving hormonal treatments for prostate cancer?
❒Yes ❒No

Bone Densitometry: Patient History Form

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Name:	**Date of Birth:**	**Today's date:**

Who ordered this bone density test? _____

Shall we fax copies of your report to any other physician? _____

What is the reason for doing this bone density test? _____

Have you had a bone density test before? ❒No ❒Yes When and where? _____

Ethnic Group: ❒Caucasian ❒Hispanic ❒Asian/Pacific Islander ❒African-American ❒Other: _____

Sex _____

May we contact you for possible participation in research studies? ❒Yes ❒No

Are there any details to any of your answers on this questionnaire you feel we should know?

_____

_____

_____

_____

For Official Use

HT					cc:		
WT	L	R	JC	MG	BW	DXA	

Notes