

# Advance Beneficiary Notice of Non-Coverage (Medicare Form CMS-R-131)

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Medicare's Advance Beneficiary Notice of Non-Coverage (ABN) is specific to Medicare fee-for-services (FFS) patients. Providers should be aware that the Medicare ABN might not be acceptable for other insurances which typically have their own requirements when informing patients that specific services are not covered under their policies. An ABN or private payor equivalent form must be presented to the patient PRIOR to providing the services in order for the patient to be able to make an informed decision on whether they will accept financial liability for specific services. [CMS instructions](#) state the following: "Don't use an ABN for Medicare Advantage (Part C) or Medicare Prescription Drug Benefit (Part D) items and services."

Providers must use the official current ABN form (Form CMS-R-131 (Exp.01/31/2026) - OMB No. 0938-0566 - listed at the very bottom). This form is available on the [Medicare website](#) along with specific [instructions](#) for completing the form. The official form should not be changed in any way but can be printed on letter or legal sized paper, is available in both English and Spanish, in large print in both languages and in Word or PDF formats. The form cannot be translated into other languages per CMS but providers may offer verbal assistance for other languages to help patients understand the document. Any language assistant provided should be documented in the "Additional Information" section of the form. Providers may complete information (Sections A-F) detailing the reason for the ABN and costs; however, sections G-I can only be completed by the patients. Under certain conditions, an ABN may be [presented electronically](#) (p 14) with the patient electronically signing. There are specific instances when [CMS requires the use of an ABN](#) which include:

"When a Medicare item or service isn't reasonable and necessary under Program standards, including care that's:

- Not indicated for the diagnosis, treatment of illness, injury, or to improve the functioning of a malformed body member
- Experimental and investigational or considered research only
- More than the number of services allowed in a specific period for that diagnosis"

There are times when CMS recommends, but does not require, the use of an ABN to ensure the patient understands their responsibility for paying for such services. For example, an ABN is recommended when providing statutory excluded services that are never covered such as a refraction (92015) - which falls under "Routine eye care, most eyeglasses and examinations (§1862(a)(7) of the Act)." You can find the lists of services and items that are not covered [here](#).

The current ABN has three options from which a patient must choose when signing an ABN:

**Option 1** assumed Medicare will not pay and allows the provider to collect the assumed outstanding Medicare allowable amount from the patient at the time of service with the understanding that any amount paid by Medicare would be immediately refunded.

**Option 2** states the patient wants the service but does not want Medicare to be billed at all and the patient is responsible for the dollar amount.

**Option 3** states that the patient is refusing the service that is thought to be non-covered.

The patient should check the appropriate box to indicate their choice, sign and date the form and should receive the original form while the provider retains a copy for their records. A patient can refuse to sign an ABN. If this happens, the refusal should be noted in the patient record and the provider can opt to not provide that service.

When an ABN has been signed, the filed claim should contain the appropriate modifier to indicate the type of ABN:

**GA**-Waiver of Liability Statement Issued, as Required by Payer

**GK**-Reasonable and Necessary Item/Service Associated with a GA or GZ modifier

**GL**-Medically Unnecessary Upgrade Provided instead of Non-Upgraded Item, No Charge, No ABN

**GY**-Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit

**GZ**-Item or Service Expected to Be Denied as Not Reasonable and Necessary

**GX**-Notice of Liability Issued, Voluntary Under Payer Policy

Remember to check each and every private payor's policy, including Medicare Advantage Plans, to ensure you are following their particular guidance for issuing notices of non-coverage. Happy Coding....