DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Official Information Health Care Professionals Can Trust

Medicare Ambulance Transports

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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

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This publication provides the following information about Medicare ambulance transports:

- The ambulance transport benefit;
- Ambulance transports;
- Ground and air ambulance providers and suppliers;
- Ground and air ambulance vehicles and personnel requirements;
- Covered destinations;
- Ambulance transport coverage requirements;
- Advance Beneficiary Notice of Noncoverage (ABN);
- Payments for ambulance transports; and
- Resources.

When “you” is used in this publication, we are referring to ambulance providers and suppliers.

THE AMBULANCE TRANSPORT BENEFIT

The ambulance transport benefit is a transport by an ambulance. The transport may be covered when the use of any other method of transportation is contraindicated due to the beneficiary’s condition and the additional requirements discussed below are met. Ambulance transports are separately payable under Medicare Part B only. Under certain circumstances, ambulance transports are covered and payable as a beneficiary transportation service under Part A.

AMBULANCE TRANSPORTS

Ground Ambulance Transport

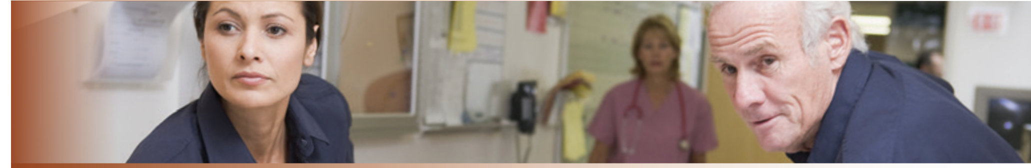
A beneficiary may be transported on land or on water for a ground ambulance transport. Ground ambulance transports include the following:

- **Basic Life Support (BLS)** – Includes the provision of medically necessary supplies and services and BLS ambulance transportation as defined by the State where you provide the transport. An emergency response is one that, at the time you are called, you respond immediately. A BLS emergency is an immediate emergency response in which you begin as quickly as possible to take the steps necessary to respond to the call;
- **Advanced Life Support, Level 1 (ALS1)** – Includes the provision of medically necessary supplies and services and the provision of an ALS assessment or at least one ALS intervention. An ALS assessment is performed by an ALS crew as part of an emergency response that is necessary because the beneficiary’s reported condition at the time of dispatch indicates that only an ALS crew is qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the beneficiary requires an ALS level of transport. An ALS intervention is a procedure that must be performed by an emergency medical technician-intermediate (EMT-Intermediate) or an EMT-Paramedic in accordance with State and local laws. An ALS1 emergency is an immediate emergency response in which you begin as quickly as possible to take the steps necessary to respond to the call;
- **Advanced Life Support, Level 2 (ALS2)** – Includes the provision of medically necessary supplies and services and:
  - At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids); or

- At least one of the following procedures:
  - Manual defibrillation/cardioversion;
  - Endotracheal intubation;
  - Central venous line;
  - Cardiac pacing;
  - Chest decompression;
  - Surgical airway; or
  - Intraosseous line;
- **Specialty Care Transport (SCT)** – Includes the provision of medically necessary supplies and services beyond the scope of an EMT-Paramedic. SCT is the interfacility transportation of a critically ill or injured beneficiary that is necessary because the beneficiary's condition requires ongoing care furnished by one or more professionals in an appropriate specialty (such as emergency or critical care nursing, emergency medicine, respiratory or cardiovascular care, or a paramedic with additional training); and
- **Paramedic Intercept (PI)** – When an entity that does not provide the ambulance transport provides ALS services. PI may be required when you can provide only a BLS level of service and the beneficiary requires an ALS level of service (such as electrocardiogram monitoring, chest decompression, or intravenous therapy). Certain additional requirements apply that, as of the publication of this booklet, are met only by certain entities operating in some western counties of New York State.

Air Ambulance Transport

A beneficiary may be transported by fixed wing (airplane) or rotary wing (helicopter) aircraft for a medically necessary air ambulance transport.



GROUND AND AIR AMBULANCE PROVIDERS AND SUPPLIERS

You may furnish ground and air Medicare ambulance transportation to a beneficiary when:

- The transportation is medically necessary;
- Any other means of transportation is contraindicated; and
- The destination is to the nearest appropriate facility that can treat the beneficiary's condition.

Ambulance Providers

An ambulance provider is a provider that owns and operates an ambulance transportation service as an adjunct to its institutionally-based operations. These providers include:

- Hospitals;
- Critical Access Hospitals (CAH);
- Skilled Nursing Facilities (SNF);
- Comprehensive Outpatient Rehabilitation Facilities;
- Home Health Agencies (HHA); and
- Hospice programs.

Although ambulance providers can and do furnish ambulance transports that are covered under Medicare Part B, an ambulance provider that transports an individual from one provider to another is generally included in the Part A provider service.

For example, a beneficiary who was admitted to a hospital, CAH, or SNF may require patient transportation, which is transportation to another hospital or other site while he or she receives specialized care and maintains inpatient status with the original provider. This transportation is covered under Part A as an inpatient hospital or CAH service. Patient transportation is covered under Part A as a SNF service when a beneficiary is a resident of a SNF and must be transported by ambulance for an intra-campus transfer between different departments of the same hospital, to receive dialysis or certain other high-end outpatient hospital services, or for transfer to another SNF. This transportation may not be billed as a Part B service. If a HHA has a beneficiary transported by ambulance to a hospital or a SNF to obtain needed medical services that are not otherwise available, the trip is covered as a Part B service only if the requirements are met for ambulance transportation from the beneficiary's place of origin. This transportation is not covered as a Home Health service.

Ambulance Suppliers

An ambulance supplier is not owned or operated by a provider and is enrolled in Medicare as an independent ambulance supplier. These suppliers include:

- Volunteer fire and/or ambulance companies;
- Local government ambulance companies;
- Privately-owned and operated ambulance companies; and
- Independently-owned and operated ambulance companies.

GROUND AND AIR AMBULANCE VEHICLES AND PERSONNEL REQUIREMENTS

Ambulance Vehicles

Ground and air ambulance vehicles must comply with State and/or local laws governing the licensing and certification of emergency medical transportation vehicles and must be designed and equipped to respond to medical emergencies. At a minimum, ambulance vehicles must be equipped with the following:

- A stretcher;
- Linens;
- Emergency medical supplies;
- Oxygen equipment;
- Other lifesaving emergency medical equipment and reusable devices (such as inflatable leg and arm splints, backboards, and neckboards);
- Emergency warning lights, sirens, and telecommunications equipment as required by State or local law; and
- A 2-way voice radio or wireless telephone.

In nonemergency situations, ambulance vehicles must be capable of transporting beneficiaries with acute medical conditions.

MEDICARE AMBULANCE TRANSPORTS

Ambulance Personnel

A BLS ambulance vehicle must be staffed by at least two individuals, one of whom must be qualified in accordance with State and/or local laws as an EMT-Basic and is legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

An ALS ambulance vehicle must be staffed by at least two individuals, one of whom must be qualified in accordance with State and/or local laws as an EMT-Intermediate or an EMT-Paramedic.

Statement About Ambulance Vehicles and Personnel

To indicate that you meet the above requirements, include the following information about your ambulance vehicles and personnel in a statement you provide to the Medicare Administrative Contractor (MAC):

- The first aid, safety, and other patient care items with which the vehicles are equipped;
- The extent of first aid training acquired by the personnel assigned to the vehicles;
- An agreement to notify the MAC of any change in operation that could affect the coverage of ambulance transports; and
- Documentary evidence (such as a letter or copy of a license, permit, or certificate issued by State and/or local authorities) indicating that the vehicles are equipped as required.

For MAC contact information, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the Centers for Medicare & Medicaid Services (CMS) website.

COVERED DESTINATIONS

Ground Ambulance Transport

When all other program requirements for coverage are met, ground ambulance transports are covered only to and from the following destinations:

- Hospitals;
- CAHs;
- SNFs;
- Dialysis facilities for End-Stage Renal Disease beneficiaries who require dialysis;
- Physicians' offices only as follows:
  - When the transport is en route to a Medicare-covered destination;
  - The ambulance stops because of the beneficiary's dire need for professional attention; and
  - Immediately thereafter, the ambulance continues to the covered destination; and
- Beneficiaries' homes.

An institution must at least meet the requirements of Sections 1861(e)(1) or 1861(j)(1) of the Social Security Act (the Act). The institution is not required to be a Medicare participating provider.

Air Ambulance Transport

When all other program requirements for coverage are met, air ambulance transports are covered only to an acute care hospital. Air ambulance transports to the following destinations are not covered:

- Nursing facilities;
- Physicians' offices; and
- Beneficiaries' homes.

AMBULANCE TRANSPORT COVERAGE REQUIREMENTS

Ground Ambulance Transports

The following coverage requirements apply to ground ambulance transports:

1) The transport is medically reasonable and necessary;
2) A Medicare beneficiary is transported;
3) The destination is local; and
4) The facility is appropriate.

Each requirement is discussed in more detail in the next column and on page 6.

1) The Transport Is Medically Reasonable and Necessary

A medically reasonable and necessary ground ambulance transport must meet the following requirements:

- Due to the beneficiary's condition, the use of any other method of transportation is contraindicated; and
- The purpose of the transport is to obtain a Medicare-covered service or to return from obtaining such service.

While you must obtain a signed Physician Certification Statement (PCS) for the ambulance transport from the beneficiary's attending physician in some circumstances, this statement does not, in and of itself, demonstrate that an ambulance transport is medically reasonable and necessary. You must retain all appropriate documentation for an ambulance transport furnished to a Medicare beneficiary on file. This documentation must be presented to the MAC upon request and may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment.

The ambulance transport is not covered if some means of transportation other than ambulance could be used without endangering the beneficiary's health, regardless of whether the other means of transportation is actually available.

2) A Medicare Beneficiary Is Transported

The transport of a Medicare beneficiary must occur for an ambulance transport to be payable under the Medicare Program. When multiple ambulance providers and suppliers respond, payment is made only if you actually transport the beneficiary.

3) The Destination Is Local

As a general rule, the ground ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the beneficiary is covered. If two or more facilities meet this requirement and can appropriately treat the beneficiary, the full mileage to any of these facilities is covered.

4) The Facility Is Appropriate

An appropriate facility is an institution that is generally equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the beneficiary's condition.

Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, there must be clear evidence indicating that an ambulance transport to a more distant institution is the nearest appropriate facility. Some circumstances that may justify ambulance transport to a more distant institution include:

- The beneficiary's condition requires a higher level of trauma care or other specialized service that is only available at the more distant hospital. A specialized service is a covered service that is not available at the facility where the beneficiary is a patient; and
- No beds are available at the nearest institution.

A ground ambulance transport to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist is not covered.

If a beneficiary is initially transported to an institution that is not equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury and is then transported to a second institution that is adequately equipped, both ground ambulance transports will be covered provided the second transport is to the nearest appropriate facility.

When a ground ambulance transports a beneficiary to and from the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a Computerized Axial Tomography scan or cobalt therapy), the transport is covered only to the extent of the payment that would have been made to bring the service to the beneficiary.

A ground ambulance transport from an institution to the beneficiary's home is covered when the home is:

- Within the locality of the institution. Locality is the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services; or
- Outside the locality of the institution but in relation to the beneficiary's home, it is the nearest appropriate facility.

Air Ambulance Transports

The following coverage requirements apply to air ambulance transports:

1) The transport is medically reasonable and necessary;
2) A Medicare beneficiary is transported;
3) The destination is local; and
4) The facility is appropriate.

Each requirement is discussed in more detail on pages 7 and 8.

1) The Transport Is Medically Reasonable and Necessary

A medically reasonable and necessary air ambulance transport must meet the following requirements:

- The beneficiary's medical condition requires immediate and rapid ambulance transport;
- It cannot be furnished by BLS or ALS ground ambulance transport because one of the following pose a threat to the beneficiary's survival or seriously endangers his or her health:
  - The point-of-pick-up (POP) is not accessible by ground vehicle (this requirement may be met in Hawaii, Alaska, and other remote or sparsely populated areas of the continental United States). POP is the location of the beneficiary at the time he or she is placed on board the ambulance. The ZIP code of the POP must be reported on the claim to apply the correct Geographic Adjustment Factor (GAF) and Rural Adjustment Factor, as appropriate;
  - The distance to the nearest appropriate facility or the time a ground ambulance transport will take (generally more than 30 – 60 minutes); or
  - The instability of ground transportation.

While you must obtain a signed PCS for the ambulance transport from the beneficiary's attending physician in some circumstances, this statement does not, in and of itself, demonstrate that an ambulance transport is medically reasonable and necessary. You must retain all appropriate documentation for an ambulance transport furnished to a Medicare beneficiary on file. This documentation must be presented to the MAC upon request and may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment.

The medical conditions that may justify air ambulance transport include, but are not limited to, the following (this list is not intended to justify air ambulance transport in all localities):

- Intracranial bleeding that requires neurosurgical intervention;
- Cardiogenic shock;
- Burns that require treatment in a burn center;
- Conditions that require treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries; or
- Life-threatening trauma.

Specialized medical services that are generally not available at all facilities include, but are not limited to, the following:

- Burn care;
- Cardiac care;
- Trauma care; and
- Critical care.

2) A Medicare Beneficiary Is Transported

The transport of a Medicare beneficiary must occur for an ambulance transport to be payable under the Medicare Program. When multiple ambulance providers and suppliers respond, payment is made only if you actually transport the beneficiary. An air ambulance transport to transfer a beneficiary from one hospital to another hospital must meet the following requirements:

- A ground ambulance transport endangers the beneficiary's health;
- The transferring hospital does not have the needed hospital or skilled nursing care for the beneficiary's illness or injury; and
- The second hospital is the nearest appropriate facility.

3) The Destination Is Local

As a general rule, the air ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the beneficiary is covered. If two or more facilities meet this requirement and can appropriately treat the beneficiary, the full mileage to any of these facilities is covered.

4) The Facility Is Appropriate

An appropriate facility is an acute care hospital that is generally equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the beneficiary's condition.

Because all duly licensed acute care hospitals are presumed to be appropriate sources of health care, there must be clear evidence indicating that an air ambulance transport to a more distant hospital is the nearest appropriate facility. Some circumstances that may justify air ambulance transport to a more distant institution include:

- The beneficiary's condition requires a higher level of trauma care or other specialized service that is only available at the more distant hospital; and
- No beds are available at the nearest hospital.

Air ambulance transport to a more distant hospital or from a hospital that is capable of treating the beneficiary to a different hospital solely to avail the beneficiary of the services of a specific physician or hospital is not covered.

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

ABN Guidance for an Ambulance Transport

In general, you must not issue an ABN to a beneficiary who has an acute medical emergency or is under duress. You are required to issue an ABN only when a beneficiary's covered ambulance transport is modified to a level that is not medically reasonable and necessary and will incur additional costs. To assist you in determining whether an ABN is required for an ambulance transport, ask yourself the following three questions:

1) Is this service a covered ambulance benefit?
2) Will payment for part or all of this service be denied because it is not reasonable and necessary?
3) Is the beneficiary stable and the transport non-emergent?

If the answer to **all** three questions is "Yes," you must issue an ABN.

General ABN Guidance for Fee-For-Service (FFS) Providers

You must give written notice to a FFS Medicare beneficiary before you provide items or services that are usually covered by Medicare, but are not expected to be paid in a specific instance (for example, a ground ambulance transport is medically necessary but the beneficiary insists on an air ambulance transport). Ambulance providers and suppliers use the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, for this purpose.

The ABN allows the beneficiary to make an informed decision about whether or not to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay. If you don't issue the ABN when notice is required, the beneficiary may not be held financially liable if Medicare denies payment. If you properly notify the beneficiary that the item or service may not be covered and the beneficiary agrees to pay, you may seek payment from the beneficiary. A copy of the ABN must be kept in the medical record, and the beneficiary must be given a copy.

If you furnish items or services to the beneficiary based on the referral or order of another provider or supplier, you are responsible for notifying the beneficiary that the services may not be covered by Medicare and that the beneficiary can be held financially liable for them if payment is denied.

You are not required to notify the beneficiary before you provide items or services that are never covered by Medicare (for example, an ambulance transport that is not covered) You may, however, choose to issue a voluntary ABN or a similar notice as a courtesy to the beneficiary to alert him or her about their forthcoming financial liability. When the ABN is issued as a voluntary notice, the beneficiary doesn't need to check an option box or sign the notice to be held liable for the excluded service.

PAYMENTS FOR AMBULANCE TRANSPORTS

An ambulance transport is paid under Part A as a packaged service or under Part B as a separately billed service. If an ambulance transport is covered and payable under Part A, it will not be covered or payable under Part B.

MEDICARE AMBULANCE TRANSPORTS

Ambulance Fee Schedule

Section 4531(b)(2) of the Balanced Budget Act of 1997 added Section 1834(l) to the Act, which mandated the implementation of a national Ambulance Fee Schedule (FS) effective for Part B ambulance transport claims with dates of service on or after April 1, 2002. The Ambulance FS applies to all ambulance transports. Section 1834(l) of the Act also required mandatory assignment for all ambulance transports, which means that you will be paid the Medicare-allowed amount as payment in full for your transports. In addition, you may bill or collect only any unmet Part B deductible and coinsurance amounts from the beneficiary.

Effective January 1, 2006, the total payment amount for ground ambulance providers and suppliers is based on 100 percent of the national Ambulance FS. Payments for ground ambulance transports under the Ambulance FS include the following elements:

- A nationally uniform base rate or conversion factor for all ground ambulance transports;
- A numeric value for ambulance transports relative to the value of a base level ambulance transport called a relative value unit is assigned to each type of ground ambulance transport;
- A GAF for each Ambulance FS locality area (geographic practice cost index [GPCI]);
- A nationally uniform loaded mileage rate;
- An additional amount for certain mileage for a rural POP; and
- Additional payments for certain specified temporary periods.

Effective January 1, 2006, the total payment amount for air ambulance providers and suppliers is based on 100 percent of the national Ambulance FS. Payments for air ambulance transports under the Ambulance FS include the following elements:

- A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;
- A GAF for each Ambulance FS locality area (GPCI);
- A nationally uniform loaded mileage rate for each type of air transport; and
- A rural adjustment to the base rate and mileage for transports furnished for a rural POP.

For more information about the Ambulance FS, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule and refer to the Medicare Learning Network® publication titled "Ambulance Fee Schedule" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AmbulanceFeeSched_508.pdf on the CMS website.

Ground Ambulance Payment When the Beneficiary Dies

The chart below provides payment information for three ground ambulance transport scenarios in which the beneficiary dies.

Ground Ambulance Payment When the Beneficiary Dies

Time of Death Pronouncement	Payment
1) Before dispatch.	• None.
2) After dispatch and before the beneficiary is loaded on board the ambulance (before or after arrival at the POP).	• Your BLS base rate; • No mileage or rural adjustment; and • Use QL modifier, "Patient pronounced dead after ambulance called," on claim.
3) After pickup and prior to or upon arrival at the receiving facility.	• A medically reasonable and necessary level of service has been furnished.

Air Ambulance Payment When the Beneficiary Dies

The chart below provides payment information for three air ambulance transport scenarios in which the beneficiary dies.

Air Ambulance Payment When the Beneficiary Dies

Time of Death Pronouncement	Payment
1) Before the beneficiary is loaded on board the ambulance: • The dispatcher receives the pronouncement of death and has a reasonable opportunity to notify the pilot to abort the flight; and • The aircraft has taxied but has not taken off or, at a controlled airport, the aircraft has been cleared to take off but has not actually taken off.	• None.
2) After take off to the POP and before the beneficiary is loaded on board the air ambulance.	• Appropriate air base rate with no mileage or rural adjustment; and • Use QL modifier on claim.
3) After the beneficiary is loaded on board the air ambulance and before or upon arrival at the receiving facility.	• As if the beneficiary had not died.

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Air Ambulance Aborted Flight Scenarios

The chart below provides payment information for two air ambulance transport scenarios in which the flight is aborted due to bad weather or other circumstances beyond the pilot's control.

Air Ambulance Aborted Flight Scenarios

Aborted Flight Scenario	Payment
1) Before the beneficiary is loaded on board the air ambulance (prior to or after take off to the POP).	• None.
2) After the beneficiary is loaded on board the air ambulance.	• Appropriate air base rate, mileage, and rural adjustment.

Multiple Beneficiary Ground and Air Ambulance Transports

Effective April 1, 2002, the following applies to multiple beneficiary ground and air ambulance transports:

- When two Medicare beneficiaries are transported to the same destination simultaneously, the payment allowance for each beneficiary is equal to 75 percent of the base rate applicable to the level of care provided to the beneficiary plus 50 percent of the total mileage payment allowance for the entire trip; and
- When three or more Medicare beneficiaries are transported to the same destination simultaneously, the payment allowance for each beneficiary is equal to 60 percent of the base rate applicable to the level of care furnished to the beneficiary and a single payment allowance for mileage will be prorated by the number of Medicare beneficiaries on board.

Both Origin and Destination Are Ambulance Providers

If both the origin and destination of ambulance transports are providers (such as hospitals, CAHs, or SNFs), the provider who seeks payment for the ambulance transport is shown in the chart below.

When Both the Origin and Destination Are Ambulance Providers

Criterion	Payment
Criterion 1: National Provider Identifier (NPI)	If the NPIs of the two providers are different: • The ambulance transport is separately billable. If the NPIs of both providers are the same: • See Criterion 2: Campus.
Criterion 2: Campus*	If the campuses of the two providers that share the same NPI are the same: • The transport is not separately billable; and • The provider seeks payment. If the campuses of the two providers are different: • See Criterion 3: Beneficiary Status – Inpatient vs. Outpatient.
Criterion 3: Beneficiary Status – Inpatient vs. Outpatient	If the beneficiary is an inpatient at both providers (inpatient status at both the origin and the destination, and the providers share the same NPI but are located on different campuses): • The transport is not separately billable; • The provider seeks payment; and • All other combinations (outpatient-to-inpatient, inpatient-to-outpatient, and outpatient-to-outpatient) are separately billable. If the point of origin is not a provider: • The transport is not covered under Part A because the beneficiary is not an inpatient of any Part A provider at the time of transport; and • Ambulance transports are excluded from the 3-day preadmission payment window.

* Campus is the physical area immediately adjacent to the provider's main buildings, other areas, and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings and any of the other areas determined to be part of the provider's campus by the CMS Regional Office.

RESOURCES

The chart below provides Medicare ambulance transport resource information.

Medicare Ambulance Transport Resources

For More Information About…	Resource
Ambulance Services Center	http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html on the CMS website
Ambulance Transports	Chapter 10 of the "Medicare Benefit Policy Manual" (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf on the CMS website Chapter 15 of the "Medicare Claims Processing Manual" (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf on the CMS website
Advanced Beneficiary Notice of Noncoverage	http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html on the CMS website
All Available MLN Products	"MLN Catalog" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right with your mobile device
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Beneficiaries	http://www.medicare.gov on the CMS website

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