South Dakota Medicaid
Advance Recipient Notice of Non-Coverage Instructions

Patient Instructions

You are receiving this notice because your medical provider has determined that there is a medical item or service that the provider thinks Medicaid will not cover. To get the item or service, you may have to pay for it yourself. The purpose of this form is to allow you a chance to ask questions about the item or service so you can make an informed decision about whether or not you wish to get the item or service.

Reasons the item or service might not be covered could include:

1. It is not medically necessary. This means that your symptoms or diagnosis do not meet the standards for the test or procedure at this time.
2. The item or service required prior authorization by South Dakota Medicaid which was denied.
3. The service is not covered in a specific setting. For example, some services are not covered in a hospital but are covered in a clinic.

As the patient you are responsible for the following:

1. Before making a decision, take your time to read the form and consider your options.
2. Ask any questions that you have about the service/item, costs, and alternative options.
3. Understand that if you want the non-covered item or service you are committing to pay for it if Medicaid does not. That means you may receive a medical bill.

If you have any questions or concerns, you can contact Medicaid at 1.800.597.1603.

Provider Instructions

This form is to be used in situations where you, as the provider, believe the item or service in question is not covered because it is:

1. Not covered per Medicaid policy or the prior authorization has been denied;
2. Not medically necessary (deemed by the ordering physician or provider);
3. Not delivered in the most appropriate setting; or
4. Doesn't meet continued stay requirements.
5. Since any payment from Medicaid is considered payment in full, in order to use this form when a patient is currently an inpatient, it must be combined with a discharge order from the treating physician/provider indicating that the acute inpatient admission has ended and it is their medical opinion that the patient is medically stable to discharge the facility. You would then be able to utilize the ARN for any charges that occurred for the custodial care after the patient was discharged but did not leave.

Provider Responsibility

Providers should explain the specific item(s)/service(s) not covered as well as the reason it is not covered to the patient (or the patient's designated decision-maker in instances where the patient has been deemed to not be able to make their own medical decisions). Patients should be encouraged to ask questions.

Inappropriate Use of the Form

This form is to be used to allow patients to make informed choices about whether to proceed with an item/service knowing that they may bear financial responsibility for its cost. Therefore, it is not to be used when:

1. The service must be provided urgently or emergently;
2. The recipient in in an altered state of mind or is not the person who normally makes their medical decisions;
3. A recipient is in the hospital and waiting to go to a different facility for on-going skilled care such as an inpatient rehabilitation hospital or a skilled nursing facility. The recipient may be asked to sign this form if they do not have a skilled need but are planning to transition to live in assisted-living or long-term care permanently.

If you have any questions or concerns you should contact 1.800.452.7691.

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South Dakota Medicaid
Advance Recipient Notice of Non-Coverage Form

Recipient Name: _____

Recipient Medicaid ID Number: _____

Non-Covered Service or Item: _____

Reason Medicaid May Not Pay: _____

Estimated Total Cost to Recipient: $_____

OR

Estimated Average Daily Cost to Recipient: $_____

Medicaid pays for most medically necessary services. However, some services may not be covered. You are responsible for paying for noncovered services. For a list of covered services please review the Medicaid handbook[1].

Medicaid payment is considered payment in full for a Medicaid provider. A Medicaid provider cannot bill any remaining balance of a covered service to you, your family, friends, or anyone else or otherwise request payment in excess of the Medicaid reimbursement rate. Providers can only bill you for noncovered services. Your provider expects this service or item may be noncovered by Medicaid.

What you need to do:

- Read this notice and make an informed decision.
- Ask the provider any questions that you may have.
- Choose an option below.

☐ Option 1: I want the service or item listed above. I understand that if Medicaid does not pay, I am responsible for payment. If Medicaid does cover the service and the provider required payment in advance, all payments made by the recipient to the provider are required to be refunded.

☐ Option 2: I do not want the service or product listed above.

This notice of non-coverage is based on your provider's opinion and is not an official Medicaid coverage determination. If you appeal and Medicaid decides to pay, any charges will be refunded. If you have questions regarding this notice or Medicaid coverage, call 1-605-773-3495.

By signing below, you are attesting that you have received this notice, understand it, and agree to the option selected above.

Patient, Parent or Legal Representative Signature	Time	Date

Provider or Authorized Staff Signature	Time	Date

[1] https://dss.sd.gov/medicaid/recipients/