OMB Approval No. 0938-0910

Insert Logo here

(Your provider logo can be inserted here. Must have name, address, phone. Make sure OMB number above remains visible)

DETAILED EXPLANATION OF NON-COVERAGE

Date: (Insert date here)

Patient Name: (Insert the client's name here. Can be handwritten.) Patient ID Number: (Insert # here)

This notice gives a detailed explanation of why your Medicare Health plan and/or provider has determined that Medicare coverage for your current {insert type} services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current {insert type} services should end.

- **The facts used to make this decision:**
  Fill in the patient-specific information that describes the current functioning and progress of the beneficiary with respect to the services provided. Use full sentences in plain English.

- **Detailed explanation of why your current services are no longer covered under your plan, and the specific Medicare coverage rules and policy used to make this decision:**
  Fill in the detailed and specific reasons why services are no longer reasonable or necessary for the beneficiary or no longer covered according to the Medicare coverage guidelines. Describe how the beneficiary does not meet these guidelines.

- **{Insert plan} policy, provision, or rationale used in making the decision:**
  Fill in reasons why services are either no longer reasonable or necessary for the enrollee or are no longer covered according to the plan's policy guidelines. Describe how the enrollee does not meet these guidelines. If the plan relied exclusively on the Medicare guidelines, indicate here.

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at {insert plan or provider telephone number}: insert your telephone #

The following information should also be present on your form. ↓

Form No. CMS-10095 (DENC) Exp Date: 8/31/2010

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- 0910. The time required to complete this information collection is estimated to average 60 to 90 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(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Do not copy and use this form! Go to www.hsag.com/providers/medicare_advantage.asp for the actual form in pdf format that you can use as well as form instructions. Font size should be a minimum of 12pt type throughout notice.

SAMPLE