

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

{insert logo here}

## NOTICE OF MEDICARE NON-COVERAGE

Patient Name: (put the clients name here, can be handwritten)

Patient ID Number: (insert # here)

(SNF, HH, hospice or CORF) ↓

THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT {insert type} SERVICES WILL END: **{insert effective date}** (effective date = discharge date)

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- Your Medicare Health plan and/or provider have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
  - You may have to pay for any {insert type} (as above) services you receive after the above date.
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### YOUR RIGHT TO APPEAL THIS DECISION

- You have the right to an immediate, independent medical review (appeal), while your services continue, of the decision to end Medicare coverage of these services.
  - If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer will also look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
  - If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
  - If you choose to appeal, and the independent reviewer agrees that services should no longer be covered after the effective date indicated above, neither Medicare nor your plan will pay for these services after that date.
  - If you stop services no later than the effective date indicated above, you will avoid financial liability.
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### HOW TO ASK FOR AN IMMEDIATE APPEAL

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally by no later than the effective date of this notice.
- Call your QIO at: {insert name and number of QIO} to appeal, or if you have questions. ↑(Health Services Advisory Group 1-800-359-9909)

**See the back of this notice for more information.**

## OTHER APPEAL RIGHTS:

- If you miss the deadline for requesting an immediate appeal with the QIO, you still may request an expedited appeal from your Medicare Health plan. If your request does not meet the criteria for an expedited review, your plan will review the decision under its rules for standard appeals. Please see your Evidence of Coverage for more information.
- Contact your plan or 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

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## ADDITIONAL INFORMATION (OPTIONAL)

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Please sign below to indicate that you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

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**Signature of Patient or Representative**

**Date**

**\* Please advise the beneficiary that HSAG's contact numbers for appeals are available for 7 days a week, including weekends and holidays.**

**(Note: Page one information should remain on page one, page two information on page two. Do not copy and use this form! Go to [http://www.hsag.com/providers/medicare\\_advantage.asp](http://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 12 point type throughout the notice.)**

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