OMB Approval No. 0938-0953

Insert Logo here

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

(SNF,HH,hospice or CORF)↓

DETAILED EXPLANATION OF [Insert type] NON-COVERAGE

Date: **(put date here)**

Patient Name: (put the clients name here, can be handwritten) Medicare Number: **(put # here)**

This notice gives a detailed explanation of why your 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 {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.

Sample

- **Detailed explanation of why these services are no longer covered, 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.

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

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 provider telephone number}:

(insert your telephone # ↑)

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

Form No. CMS-10124 Exp. Date 07/31/2011

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 0938-0953. The time required to distribute this information collection is 1 hour per notice, including the time to select the preprinted form, gather the needed information, complete the form, and deliver it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.