

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

{Insert logo here}

NOTICE OF MEDICARE PROVIDER NON-COVERAGE

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

Medicare 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 provider has 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 and you should be available to answer questions or supply information. 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, Medicare will not 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 two days after 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 page 2 of this form for more information.

OTHER APPEAL RIGHTS:

- If you miss the deadline for filing an immediate appeal, you may still be able to file an appeal with a QIO, but the QIO will take more time to make its decision.
- Contact 1-800-MEDICARE (1-800-633-4227), or TTY/TDD: 1-877-486-2048 for more information about the appeals process.

ADDITIONAL INFORMATION (OPTIONAL)

Sample

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.

Signature of Patient or Authorized Representative

Date

*** Please advise the beneficiary that HSAG's contact numbers for appeals are available 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 www.hsag.com/providers/fee_for_service.asp for the actual form in pdf you can use and the form instructions. Font size should be a minimum of 12 pt type throughout notice.)

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

Form No. CMS-10123

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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 prepare and distribute this collection is 10 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the enrollee. If you have 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.