OMB Approval No. xxxx-xxxx

Insert Logo here

DETAILED EXPLANATION OF [Insert type] NON-COVERAGE

Date:
Patient Name: ~~Medicare~~ Patient ID Number:

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 current {insert type} services should end.

- **The facts used to make this decision:**

- **Detailed explanation of why these services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:**

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}: