## **Insert Logo here**

## **DETAILED EXPLANATION OF [Insert type] NON-COVERAGE**

Date: Patient Name:	Patient ID Number:
Medicare coverage for you	d explanation of why your provider has determined that ur current {insert type} services should end. <i>This notice is not peal.</i> The decision on your appeal will come from your Quality (QIO).
We have reviewed your of {insert type} services should be a service of the servic	case and decided that Medicare coverage of your current ould end.
• The facts used to	o make this decision:
	tion of why these services are no longer covered, and the e coverage rules and policy used to make this decision:
	the policy or coverage guidelines used to make this decision, s sent to the QIO, please call us at {insert provider telephone

Form No. CMS-10124 Exp. Date xx/xx/xxxx

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 beneficiary. 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.