[SAMPLE]

We,[insert name of HHA], your home health agency, are letting you know appropriate clause] with the following items and/or services:[Describe affected items and/or services:]	
Because: [Describe appropriate reason]	
If you have questions about these changes, you can call us at _(
INSERT:	
OPTION BOX 1 TEXT: Use when items and/or services may be provided that will not be paid for	by Medicare.
OR	
OPTION BOX 2 TEXT: Use when items and/or services will no longer be provided for financial a reasons.	AND/OR OTHER
OR	
Option Box 3 text: Use when physician's orders reduce certain items and/or services.	
Detient's Norma	ant I dout : Cootion
Patient's Name Patie	ent Identification
Signature of the Patient or of the Authorized Representative Date	2
Please read and sign this notice. Return it to us or mail it to our address listed abov	/e.
According to the Panerwork Peduction Act of 1005 no persons are required to respond to a collection of information unless it display	ave a valid OMP control number

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 0938-0781. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form No.	CMS-R-296	(08/2012))
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[Option Box 1 Sample]	
We,, your home health agency, are letting you be with the following items and/or services:	
Because:	
If you have questions about these changes, you can call us at _() TTY users should call _()	
The estimated cost of the items and/or services listed above is \$	
If you have other insurance, please see number 3 below.	
 You have three options available to you. You must choose only one of these option the option and then signing below: I. I don't want the items and/or services listed above. I understand that I won't be and that I have no appeal rights since I will not receive those items and/or services listed above, and I agree to pay myself since want a claim submitted to Medicare or any other insurance I have. I underst have no appeal rights since a claim won't be submitted to Medicare. J. I want the items and/or services listed above, and I agree to pay myself since want a claim submitted to Medicare or any other insurance I have. I underst have no appeal rights since a claim won't be submitted to Medicare. J. I want the items and/or services listed above, and I agree to pay for the items services myself if Medicare or my other insurance doesn't pay. Send the cla (Please check one or both boxes): Medicare My other insurance: Please note: If you select option 3 and a claim is submitted to Medicare, you will g Notice (MSN) showing Medicare's official payment decision. If the MSN indicates or part of your claim, you may appeal Medicare's decision by following the appeal p you don't receive a MSN for your claim, you can call Medicare at: 1-800-633-4227. You may have to pay the full cost at the time you get the items and/or services. If N insurance decides to pay for all or part of the items and/or services that you have all receive a refund for the appropriate amount. 	be billed ervices. I don't and that I and/or im to get a Medicare Summary that Medicare won't pay all procedures in the MSN. If TTY: 1-877-486-2048. Medicare or your other
By signing below , I understand that I received this notice because this Home Health will not pay for the items/services listed, and so I chose the option checked above.	n Agency believes Medicare
Patient's Name	Patient Identification
Signature of the Patient or of the Authorized Representative	Date
Please read and sign this notice. Return it to us or mail it to our address listed a	

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[Option Box 2 Sample]

We,, your home health agency, are with the following items and/or server	
Because:	
If you have questions about these changes, you can call us at	· <u>.</u>
TTY users should call (
By signing below , I understand that I received this notice because this providing the items and/or services listed above. The Agency's decisi coverage or other health insurance coverage. I can't appeal to Medicar provide me with any more items and/or services; however, I can try to another Home Health Agency.	Home Health Agency decided to stop on doesn't change my Medicare re since this Home Health Agency won't get the items and/or services from
Please note that there are many different ways to find another Home H your doctor who originally ordered home care. You may then ask the Medicare or your other insurance for items and/or services you receive	new Home Health Agency to bill
Patient's Name	Patient Identification
Signature of the Patient or of the Authorized Representative	Date
Please read and sign this notice. Return it to us or mail it to our ad According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of	

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[Option Box 3 Sample]

We,, your home health agency, are letting you l with the following items and/or services:	know that we
Because:	
If you have questions about these changes, you can call us at _() TTY users should call _()	
By signing below , I understand that I received this notice because my doctor changed my orders and so my home health plan of care is changing. This Hot Health Agency has explained to me that they cannot provide home care witho doctor's order.	ne
Patient's Name	Patient Identification
Signature of the Patient or of the Authorized Representative	Date

Please read and sign this notice. Return it to us or mail it to our address listed above.

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 0938-0781. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.