
Insert ~~Logo~~ contact information here

DETAILED EXPLANATION OF NON-COVERAGE

Detailed Explanation of Non-coverage

Date:

Patient ~~N~~name:

Patient ~~ID~~ Number~~number~~:

This notice gives a detailed explanation of why your Medicare ~~H~~health plan and/or 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.

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

• **Detailed explanation of why your current services are no longer covered under ___ your ~~plan~~, and the specific Medicare coverage rules and policy used ~~to make~~ ___ this decision:**

• **Plan policy, provision, or rationale used in making the 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 plan or provider telephone number}~~

~~Form No. CMS-10095 (DENC) _____ Exp Date: _____~~

~~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 Approval No. 0938--0910. The time required to complete this information collection is estimated to average 60 to 90 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(s) 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.~~
