

~~{Insert provider contact information here}~~
~~NOTICE OF MEDICARE NON-COVERAGE~~

~~Patient name: _____ Patient number: _____~~

~~THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT {insert type}
SERVICES WILL END: {insert effective date}~~

- ~~• Your Medicare health plan and/or provider have 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 services you receive after the above date.~~

~~**-Form Instructions for the Notice of Medicare Non-Coverage
(NOMNC) CMS-10095**~~

~~**When to Deliver the NOMNC**~~

~~A Medicare health provider must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to enrollees receiving skilled nursing, home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services, no later than two days before the termination of services. This notice fulfills the requirement at 42 CFR 422.624(b)(1) and (2). In situations where the termination decision is not delegated to a provider, the plan must provide the service termination date to the provider not later than two days before the termination of services for timely delivery to occur.~~

~~**Valid Notice Delivery**~~

~~The notice must be validly delivered. Valid delivery means that the enrollee must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The enrollee must be able to understand that he or she may appeal the termination decision. If the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative.~~

~~Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee is not able to physically sign the notice to indicate receipt, then delivery may be proven valid by other means.~~

~~Valid delivery also requires delivery of an Office of Management and Budget (OMB) - approved notice consistent with either the standardized OMB-approved original notice format, or a Centers for Medicare and Medicaid Services (CMS) regional office approved variation of the OMB-approved format. Details regarding what constitutes an~~

approved variation of an OMB-approved format are included in these form instructions and manual guidance. (CMS Medicare Managed Care Manual, Chapter 13, Rev. 88, 09-21-07.)

In general, notices are valid when all patient specific information required by the notice is included, and any non-conformance is minor; that is, the non-conformance does not change the meaning of the notice or the ability to request an appeal. For example, misspelling the word “health” is a minor non-conformance of the notice that would not invalidate the notice. However, a transposed phone number on the notice would not be considered a minor non-conformance since the enrollee would not be able to contact the QIO and or health plan to file an appeal. Errors brought to the attention of the plan or provider should also be reported to the regional office plan manager. The plan manager may assist the plan in correcting the error, determine what corrective action may be required, and re-approve any subsequent variations of the NOMNC.

Notice Delivery to Incompetent Enrollees in an Institutionalized Setting

CMS requires that notification of changes in coverage for an institutionalized enrollee who is not competent be made to a representative acting on behalf of the enrollee. Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered.

The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. Place a dated copy of the notice in the enrollee's medical file. When notices are returned by the post office with no indication of a refusal date, then the enrollee's liability starts on the second working day after the provider's mailing date.

Special Circumstances

Do not use the NOMNC if coverage is being terminated for any of the following reasons:

- Because the Medicare benefit is exhausted;
- For denial of Medicare admission;
- For denial of non-Medicare covered services; or
- Due to a reduction or termination of a Medicare service that does not end the skilled Medicare stay.

In these cases, the plan must issue the CMS form 10003 - Notice of Denial of Medical Coverage (NDMC).

Modifications to the NOMNC

The NOMNC is a standardized notice. Therefore, plans and providers may not re-write, re-interpret, or insert non-OMB-approved language into the body of the notice except where indicated. Without CMS regional office approval, however, you may modify the notice for mass printing to indicate the kind of service being terminated if only one type of service is provided by the facility; that is, skilled nursing, home health, or comprehensive outpatient rehabilitation facility. You may also modify the form to reference the kind of plan issuing the notice. Notices may not be highlighted or shaded. Additionally, text must be no less than 12-point type, and the background must be high contrast. Please note that the CMS form number and the OMB control number must be displayed on the notice.

Substantive modifications, such as wrapping a letter format around the notice, may not be adopted without regional office approval. Regional office approval must be obtained for each modification not described in these instructions or other CMS guidance. Plans should contact their CMS regional office for additional questions regarding modifications to the notice.

Heading

Contact information: The name, address and telephone number of the provider that delivers the notice must appear above the title of the form. The provider's registered logo may be used.

Member number: Providers may fill in the enrollee's unique medical record or other identification number. Note that the enrollee's HIC number may not be used.

THE EFFECTIVE DATE YOUR {INSERT TYPE} SERVICES WILL END: {Insert Effective Date}: Fill in the type of services ending, **{home health, skilled nursing, or comprehensive outpatient rehabilitation services}** and the actual date the service will end. Note that the date should be in no less than 12-point type. If handwritten, notice entries must be at least as large as 12- point type and legible.

YOUR RIGHT TO APPEAL THIS DECISION

- ~~• You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.~~
- ~~• If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will 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 services should no longer be covered after the effective date indicated above, neither Medicare nor your plan will pay for these services after that date.~~
- ~~• If you stop services no later than the effective date indicated above, you will avoid financial liability.~~

Bullet # 1 not applicable

~~Bullet # 2 not applicable~~

~~Bullet # 3 not applicable~~

~~Bullet # 4 not applicable~~

~~Bullet # 5 not applicable~~

~~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 no later than the effective date of this notice.~~
- ~~• Call your QIO at: {insert name and number of QIO} to appeal, or if you have questions.~~

~~**See the back of this notice for more information.**~~

~~OTHER APPEAL RIGHTS:~~

- ~~• If you miss the deadline for requesting an immediate appeal with the QIO, you still may request an expedited appeal from your Medicare Health plan. If your request does not meet the criteria for an expedited review, your plan will review the decision under its rules for standard appeals. Please see your Evidence of Coverage for more information.~~
- ~~• Contact your plan or 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.~~

~~PLAN CONTACT INFORMATION:~~

ADDITIONAL INFORMATION (OPTIONAL):

~~Please sign below to indicate 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 Representative _____ **Date** _____

Bullet # 1 not applicable

Bullet # 2 not applicable

Bullet # 3 not applicable

Bullet # 4 Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than 12-point type.

Signature page:

Plan contact information: The plan's name and contact information must be displayed here for the enrollee's use in case an expedited appeal is requested or in the event the enrollee or QIO seeks the plan's identification.

Optional: Additional information. This section provides space for additional pertinent information that may be useful to the enrollee. It may not be used as a

Detailed Explanation of Non-Coverage, even if facts pertinent to the termination decision are provided.

Signature line: The enrollee or the representative must sign this line.

Date: The enrollee or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered.

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 **0938-0910**. The time required to complete this information collection is estimated to average **15 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, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.