Form Instructions for the Notice of Denial of Payment
CMS-10003-NDP

A Medicare health plan ("plan") is to complete and issue this notice when it denies a request for payment of a service already received. This is not model language. This is a standard form.

We are permitting plans to use their existing system generated formats that produce other notifications, as long as the back or a separate attachment contains the appeals language, verbatim, as stated on the second page of the Notice of Denial of Payment. However, if the plan does not currently generate the Explanation of Benefits format, it must use the Notice of Denial of Payment in its entirety. The OMB approval number must be displayed on the notice.

Heading

- Date: Enter the month, day, and year the notice is being issued.
- Beneficiary's name: Enter the full name of the enrollee.
- Member number: Enter the enrollee's unique identification number. (HIC number must not be used.)
- We: Enter the plan's name.
- Recently received a claim for: Enter the medical services rendered or items provided to the enrollee.
- Provided to you by: Enter the physician's or supplier's/provider's name.
- We will not pay for: Enter the medical services rendered or items already provided to the enrollee that the plan will not cover.
- Because: The plan must provide a specific and detailed explanation why the medical services rendered or items already provided to the enrollee are not covered, with the description of any applicable Medicare coverage rule or any other applicable plan policy upon which the claim denial decision was based.

Section Titled: What If I Don't Agree With This Decision?

No information is required to be completed.

Section Titled: Who May File An Appeal?

In the spaces provided, the plan is required to enter the plan's telephone and TTY numbers where the enrollee can learn how to name a representative.

Section Titled: How Do I File An Appeal?

The plan must provide the address where the enrollee or representative can mail or hand deliver an appeal.

Section Titled: What Do I Include With My Appeal?

No information is required to be completed.

Section Title: What Happens Next?

No information is required to be completed.

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Section Titled: Contact Information.

In the spaces provided, the plan is required to enter the plan's telephone and TTY numbers where the enrollee or representative can call if they need information or help.

Section Titled: Other Resources To Help You.

No information is required to be completed.

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 **0938-0829**. The time required to complete this information collection is estimated to average **10 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, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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