

**Insert contact information here**

## **Detailed Explanation of Non-coverage**

---

Date:

Patient name:

Patient number:

---

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current 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.**

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

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

• **Plan policy, provision, or rationale used in making the decision (health plans only):**

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 provider/plan toll-free telephone number}