

**Insert contact information here**

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

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Date:

Patient name:

Patient number:

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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}

*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 0938-0953. If you have comments 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.*