Insert contact information here

Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice explains why your provider and/or health plan decided 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).

**Why your services are no longer covered**

We reviewed your case and decided that Medicare coverage of your {insert type} services should end.

* **The facts used to make this decision:**
* **Detailed explanation of why your services are no longer covered, and the Medicare coverage rules used to make this decision:**
* **Specific plan policy used to make the decision (health plans only):**

To get a copy of the rules or guidelines used to make this decision, or a copy of the documents sent to the QIO, call us at {insert provider/plan toll-free telephone number}.

Form CMS-10124-DENC OMB Approval No. 0938–0953 / exp. xx-xx-202x

You have the right to get your information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you’ve been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice,](https://www.medicare.gov/about-us/nondiscrimination/accessibility-nondiscrimination.html) or call 1- 800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.