Insert contact information here

Detailed Explanation of Non-coverage

Date:	
Patient name:	Patient number:
ratient name.	ratient number.
This notice explains why your provider a for your current services should end. Thi appeal. The decision on your appeal will Organization (QIO).	nd/or health plan decided Medicare coverage is notice is not the decision on your Il come from your Quality Improvement
Why your services are no longer covered	
We reviewed your case and decided that services should end.	: Medicare coverage of your {insert type}
• 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 udocuments sent to the QIO, call us at {in number}.	used to make this decision, or a copy of the essert provider/plan toll-free telephone

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, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

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