Instructions for Completion of the HINN 12

A. General Instructions. As with comparable notices, legal or letter-size paper may be used for reproduction of this notice. All information should remain on the same page as it appears in this instruction. If possible, hospitals should use the exact font given in the notice, Times New Roman, 12-point, otherwise another comparable font at least 12-point in size, 18-point for the title should be used. A visually high-contrast combination of dark ink on a pale background must also be used. Do not use font effects, such as bolding, italicizing, or highlighting, other than those appearing in this instruction.

Entries for all blanks on the notices can be hand-written, but handwriting must be legible. The handwriting should be no smaller than approximately font size 10. If typing entries into the notice, font size 12 is recommended, but size 10 is also permissible.

B. HINN-12 Specific Instructions. The model notice itself appears at the end of these instructions. Other general guidance for the reproduction of this specific notice include the following:

- The notice is produced as a one-page document.
- The following text should be removed before reproducing the notice: "Insert Hospital Letterhead And/Or Contact Information"; "Insert Reason Medicare Is Not Expected To Pay"; and "Insert Estimated Total or Average Daily Cost".
- The following detailed instructions for completing the notice are in two parts: the header section on the first page and the remainder of the first page.

1. Header Section (Page 1 from Top to "*Insert Hospital Letterhead…*")

Retain the HINN 12 title. Remove the instruction about inserting the letterhead. Insert hospital letterhead, logo and/or basic contact information: hospital name, address and telephone number. If the letterhead or logo does not provide the basic contact information, it must be added here.

2. Instructions for Completing the notice (Remainder of Page after Header)

A. "Name of Patient or Representative"
Write legibly or pre-print the name of the patient or representative affected by this notice.

B. "Identification Number"
Write legibly or pre-print the identification number of the affected Medicare beneficiary [**Note:** Health Insurance Card (HIC) numbers must not be placed on the notice].

C. Purpose of Notice and "Reason Medicare is not Expected to Pay"
The purpose of the notice is to inform the beneficiary that the hospital believes that his/her continued hospital stay will not be covered by Medicare. Hospitals must specify,

in plain language the reason for noncoverage of the stay, including a brief description of and citations to the appropriate Medicare coverage policies or guidelines.

D. "...we believe that beginning on ______"
Fill in the date upon which the beneficiary will become responsible for payment.

E. "Insert Estimated Total or Average Daily Cost"
Insert the estimated cost of the beneficiary's stay beginning from the date of noncoverage. This estimate can be an average daily cost.

F. Physician Referral
Advise the beneficiary to speak with his/her physician about his/her health care needs, including continuing his/her current stay.

H. "Signature of Beneficiary or Representative" and "Date"
The notice must be signed and dated by the beneficiary or representative.

The beneficiary or representative must receive a copy of the signed and dated notice.

Model HINN 12 - Noncovered Continued Stay

INSERT HOSPITAL LETTERHEAD AND/OR CONTACT INFORMATION

_________________________________	____________________________
Name of Patient or Representative	Identification Number

The purpose of this notice is to inform you that we believe your continued hospital stay will not be paid for by Medicare because:

{*Insert Reason Medicare Is Not Expected To Pay*}

Based on our understanding of Medicare policy, we believe that beginning on _________________ you will be responsible for payment of your continued stay. **Beginning on this date, you or your other insurance may have to pay for your continued stay. We estimate the cost of your continued stay to be:**

{*Insert Estimated Total or Average Daily Cost}*

You should talk with your physician about your health care needs, including your continued stay.

You can ask us to file a Medicare claim for your continued stay. You will receive a Medicare Summary Notice (MSN) telling you Medicare's payment decision on this claim, and how to ask for an appeal of that decision if Medicare does not pay. If you appeal and Medicare decides to pay despite our opinion, any charges we collected (minus co-pays and deductibles) will be refunded to you. If you have questions you can call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

This notice is not an official Medicare decision. Your signature below only shows that you have received this notice and understand what you may have to pay for. You will receive a copy of this notice.

____	_______________
Signature of Beneficiary or Representative	Date