INTERMEDIARY DETERMINATION OF NONCOVERAGE

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), the Medicare intermediary advised us that the services you receive will no longer qualify as covered under Medicare beginning (Date).

The Medicare intermediary will send you a formal determination as to the noncoverage of your stay after (Date). If you wish to appeal, the formal notice will contain information about how this can be done. The intermediary will inform you of the reason for denial and your appeal rights.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier, in person or by telephone, were unsuccessful.

Please verify receipt of this notice by signing below.

Sincerely yours,

_____
Signature of Administrative Officer

VERIFICATION OF RECEIPT OF NOTICE

A. This acknowledges that I received this attached notice of noncoverage of services under Medicare on (date of receipt).

_____
(Signature of Beneficiary or Person
acting on Beneficiary's behalf

B. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____
(Name of Beneficiary or
Representative contacted)

_____
(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

UR COMMITTEE DETERMINATION OF ADMISSION

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), our Utilization Review Committee reviewed your medical information available at the time of, or prior to your admission, and advised us that the services (you or beneficiary's name) needed do not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason the services were determined to be noncovered.)

This decision has not been made by Medicare. It represents the Utilization Review Committee's judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request us to submit one. Furthermore, if you want to appeal this decision you must request that a bill be submitted. If you request a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination you may file an appeal.

You must also request that a bill be submitted to Medicare if you have questions concerning your liability for payment for the services you received.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____
Signature of Administrative Officer

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

/ / A. I want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

/ / B. I do not want my bill submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if a bill is not submitted.

NOTE: You are not required to pay for services until a Medicare decision has been made.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received the notice of noncoverage of services under Medicare on (date of receipt).

_____
(Signature of Beneficiary or Person
acting on Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____
(Name of Beneficiary or
Representative contacted)

_____
(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

UR COMMITTEE DETERMINATION ON CONTINUED STAY

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date) our Utilization Review Committee reviewed your medical information and found that the services furnished (you or beneficiary's name) no longer qualified for payment by Medicare beginning (Date).

The reason for this is: (Insert specific reason services were determined to be noncovered).

This decision has not been made by Medicare. It represents the Utilization Review Committee's judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the covered services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision you must request that the bill submitted to Medicare include the services our URC determined to be noncovered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want the bill for services after (date) submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____
Signature of Administrative Officer

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

/ / A. I want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. You will be notified when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

/ / B. I do not want my bill for services submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if a bill is not submitted.

NOTE: You are not required to pay for services until a Medicare decision has been made.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

_____
(Signature of Beneficiary or Person
acting on Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____
(Name of Beneficiary or
Representative contacted)

_____
(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DETERMINATION ON ADMISSION

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), we reviewed your medical information available at the time of, or prior to your admission, and we believe that the services (you or beneficiary's name) needed did not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason services are determined to be noncovered.)

This decision has not been made by Medicare. It represents our judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request that a bill be submitted. Furthermore, if you want to appeal this decision, you must request that a bill be submitted. If you request that a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

If you have questions concerning your liability for payment for services you received prior to the date of this notice, you must request that a bill be submitted to Medicare.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____
Signature of Administrative Officer

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

/ / A. I want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

/ / B. I do not want my bill submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if no bill is submitted.

NOTE: You are not required to pay for services until a Medicare decision has been made.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

_____
(Signature of Beneficiary or Person
acting on Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____
(Name of Beneficiary or Representative contacted)

_____
(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DETERMINATION ON CONTINUED STAY

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), we reviewed your medical information and found that the services furnished (you or beneficiary's name) no longer qualified as covered under Medicare beginning (Date).

The reason is: (Insert specific reason services are considered noncovered.)

This decision has not been made by Medicare. It represents our judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be noncovered. Medicare will notify you of its determination. If you disagree with that determination you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____
Signature of Administrative Officer

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

/ / A. I want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

/ / B. I do not want my bill for services I continue to need to be submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if a bill is not submitted.

NOTE: You are not required to pay for services until a Medicare decision has been made.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

_____
(Signature of Beneficiary or Person acting on Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____
(Name of Beneficiary or Representative contacted)

_____
(Signature of Administrative Officer)

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