Insert Logo here

DETAILED EXPLANATION OF NON-COVERAGE

Date: Patient Name:	Patient ID Number:
determined that Medicare cov	explanation of why your MA plan and/or provider has verage for your current {insert type} services should end. vion on your appeal. The decision on your appeal will come ent Organization (QIO).
We have reviewed your cas {insert type} services shou	se and decided that Medicare coverage of your current ld end.
The facts used to n	nake this decision:
<u>-</u>	on of why your current services are no longer covered n, and the specific Medicare coverage rules and policy decision:
• {Insert MA plan} po	olicy, provision, or rationale used in making the decision
	e policy or coverage guidelines used to make this decision, ent to the QIO, please call us at {insert MA plan or provider

Form No. CMS-10095 Exp. Date 03/31/2007 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-NEW. The time required to distribute this information collection is 60 - 90 minutes per notice, including the time to select the preprinted form, gather the needed information, complete the form, and

collection is 60 - 90 minutes per notice, including the time to select the preprinted form, gather the needed information, complete the form, and deliver it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.