Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-00-95 **Date: DECEMBER 14, 2000**

This Program Memorandum re-issues Program Memorandum A-99-48, Change Request 651 dated November 1999. The only change is the discard date; all other material remains the same.

This Program Memorandum re-issues Program Memorandum A-98-42, Change Request 651 dated November 1998. The only change is the discard date; all other material remains the same.

Change Request #651

SUBJECT: Renewal of Program Memorandum (PM) A-97-8--Instructions to Implement the New Medicare Summary Notice (MSN) Combined with Program Memorandum AB-98-31—ACTION

This PM replaces PM A-97-8, dated July 1997, and combines it with the intermediary instructions in PM AB-98-31, dated June 1998. There are no systems changes required as a result of this Program Memorandum -- it is simply a renewal of an existing PM.

A hard copy of the exhibits (which cannot be communicated electronically) has been sent to the regional offices (RO) to forward to you. If you have not yet received the exhibits, contact your RO. This PM includes Spanish translations of the messages. The following Spanish messages have undergone slight modifications. You do not need to make any changes to your Spanish messages at this time; however, we are providing this list for your information so that you can make changes in the future.

MSN Spanish Messages - Revised

1.1	16.17	27.2
1.2	16.19	27.4
2.1	16.23	27.5
4.1	16.38	27.6
5.2	16.40	27.7
5.6	16.42	27.9
8.2	16.43	29.6
8.3	17.6	29.9
8.16	20.8	29.17
8.41	21.12	30.2
8.47	21.13	30.4
8.50	21.14	36.1
11.5	21.15	36.2
11.6	21.17	31.4
14.13	23.3	31.5
15.17	23.10	31.6
16.1	24.12	31.14
16.2	26.5	41.1
		41.7

These instructions should be implemented within your current operating budget.

This PM may be discarded November 30, 2001.

Contact person for this PM is Julie Simms (410) 786-6343.

Attachment

3726. EXPLANATION OF THE MEDICARE SUMMARY NOTICE (MSN)

The MSN is used to notify Medicare beneficiaries of action taken on intermediary and carrier processed claims. The MSN provides the beneficiary with a record of services received and the status of any deductibles. The MSN also informs the beneficiary of appeal rights. Furnish an MSN to beneficiaries in most situations to describe health services claims made on their behalf to participating hospitals, CAHs, CSSs, OPTs, SNFs, HHAs, FQHCs, RDFs, CMHCs, CORFs, Hospices, and RHCs. For situations where an MSN may be suppressed, refer to §3726.13.

The MSN replaces the following documents:

- Part A Medicare Benefit Notice, Form HCFA 1533, also known as the Part A Notice of Utilization sent for inpatient services;
- Explanation of Medicare Benefits Notice, sent for outpatient claims;
- Form HCFA 1954, Benefit Denial Letter (BDL) sent for partially denied claims; and
- Form HCFA 1955, BDL sent for totally denied claims.

Since HCFA eliminated BDLs, Medicare beneficiaries will receive the information previously conveyed via BDLs through narrative messages contained on the MSN. Providers will no longer receive a separate written notification, or copy of the BDL. Providers must utilize the coding information (e.g., ANSI Reason Codes) conveyed via the financial remittance advice to ascertain reasons associated with Medicare claims determinations affecting payment and applicable appeal rights and/or appeals information.

3726.1 GENERAL INFORMATION ABOUT THE MSN

The MSN is specifically designed as a summary notice to beneficiaries. Providers receive a summary voucher and check under procedures described in MIM §3702. Send notices to beneficiaries for outpatient and inpatient claims combined in one notice once every 31 days. Send notices with payment due to the beneficiary as they are processed, or according to your present schedule. Make payments within claims payment floors and ceilings as outlined in MIM §3600.1.

When requested by the quality assurance (QA) staff, produce an exact copy of the MSN sent to the beneficiary for QA reviews. If the beneficiary requests a replacement copy, you must be able to produce an exact copy as it was originally generated or produce an MSN containing only the claim information requested by the beneficiary, even though it may have been part of a summary. Copies for claims processed prior to the MSN format (generated as EOMBs) may be produced in the MSN format. You must also generate an MSN upon the beneficiary's request for previously suppressed claim information (fraud and general information messages can be based on current file information). The beneficiary's request will determine the type of copy that you send.

Computer generate the entire front of the form. Preprint or computer generate the back of the form. To the extent that you have capability to perform duplex printing, exercise that option.

You must have the capability to issue the MSN in Spanish, as per beneficiary's request. To assess beneficiary's preference for a MSN in Spanish, you may print a message, every 6 months, in the General Information section, which informs beneficiaries that they may request the MSN in Spanish, or, you may use the Automated Response Unit (ARU) to inform beneficiaries that they may request their MSNs in Spanish. You may also use a beneficiary newsletter or other options to publicize the Spanish version of the MSN. Following is a sample message:

> "To provide you with the best possible service, the Medicare Summary Notice is now available in Spanish. If you or someone you know would like to receive the Medicare Summary Notice in Spanish please contact us at 1-XXX-XXX-XXXX."
>
> Spanish version: "Si usted o alguien que usted conoce desea recibir el Resumen de Medicare en Español, favor de llamarnos al 1-XXX- XXX-XXXX." (If you want this message to appear on an English MSN, which has only English characters, you may omit the special Spanish characters and print the Spanish words using English characters).

Please note that slight modifications may have to be made to the Spanish version of the MSN so that all information will fit on the notice.

Sample exhibits are provided in §3726.20 and are referenced throughout the text. Please note that, in the event of a discrepancy, the written instructions take precedence over the exhibits.

There are various messages which appear on the MSN: Help Stop Fraud messages, claims processing messages, Deductible messages and General Information messages. Each of these is described briefly here, to clarify the differences between them. Further instructions are provided in the appropriate sections.

Help Stop Fraud messages, found in the Help Stop Fraud portion in the title section of the MSN, are to alert beneficiaries of local fraud scams. For example, if someone is illegally offering free cheese and milk in exchange for Medicare numbers, you may design a message telling beneficiaries not to give out their Medicare numbers in exchange for free cheese and milk. To be effective, the Help Stop Fraud messages must be timely and specific. Review them at least every 6 months to determine if a new message should be used. You may also change them as often as necessary. Help Stop Fraud messages which you develop must be approved by the regional office (RO). Since space is limited in the Help Stop Fraud section, you may use the General Information section for lengthy messages. Some sample Help Stop Fraud messages are provided in §3726.21(A)(24).

Claims processing messages are specific messages related to the claims. They are found in the Notes section of the MSN. To ensure all claims processing messages are uniform throughout the Medicare program, do not use locally developed claims processing messages until approved and assigned a number by HCFA Central Office (CO). Send draft claims processing messages for review to your RO along with an explanation of necessity. The RO will review the messages and forward those it recommends to CO for approval. CO will respond to these requests, and notify all carriers of any additional claims processing messages that have been approved. The Division of Contractor Customer Service, Center for Beneficiary Services, in HCFA CO will assign a number to the new claims processing message(s).

Deductible Information messages inform beneficiaries of the status of their deductible throughout the year. Messages are provided in §3726.21(A)(37).

The General Information section is designed to inform beneficiaries of local health fairs and Medicare seminars, as well as to list those messages provided and those mandated by HCFA. General Information messages which you develop must be approved by the RO. The RO will determine the appropriate length of time to display each message. General Information messages may be found in §3726.21(A)(38).

You must develop the Spanish translation for any message you develop locally.

3726.2 BASIC CONCEPTS AND APPROACHES

The MSN is the notice to a beneficiary that displays data for claims processed during the reporting period. The MSN lists claim information in a summarized format.

Each MSN consists of the following four sections.

· Title Section
· Claims Information Section
· Message Section (includes Notes, Deductible and General Information sections)
· Appeals Section

For technical specifications, refer to §3726.4.

Use bar coding to obtain postal service discounts. If your system permits, and multiple MSNs are available for mailing, enclose all MSNs in the same envelope.

One MSN should be produced for Part B outpatient claims with services furnished in different calendar years. However, the "Deductible Information" section should contain the appropriate deductible information for each calendar year represented on the MSN. Similarly, MSNs with Part A inpatient claims for services furnished in more than one benefit period should contain deductible information for each benefit period reflected on the MSN. However, if message 37.10 applies to multiple inpatient claims on the same MSN, list it only once in the deductible section.
If you are mailing payment to the beneficiary for more than one claim, combine all payments to the beneficiary in one check. The MSN itself will provide the check summary information. MSNs with payment to the beneficiary should include the check in the same envelope.

MSNs are a combination of fixed and variable length sections. There are blocks around the "Claim Information" and "Notes" sections which are variable in size. Establish page breaks as specified by these instructions and exhibits.

3726.3 FORMAT FOR THE MSN

To assure uniformity in the MSN, follow these instructions:

- Generate all MSN forms by a laser printer;
- Ensure that the MSN is printed on 8 ½ by 11 inch paper, exclusive of perforated marginal pin-feed tabs;
- Use "equivalent to" point sizes in the specifications;
- Use upper and lower case letters as well as bold printing throughout the form. With the exception of the beneficiary's name and address (and dollar amounts, if necessary), print all information using proportional fonts similar to the Times New Roman fonts used in the exhibits;
- Print beneficiary master file information (i.e., beneficiary's name and address) in upper case letters, to conform to postal regulations;
- Print the following elements in fixed pitch font if you are unable to use a proportional font: beneficiary's name, beneficiary's mailing address and dollar amounts;
- Print billing provider's name(s) and mailing address(es) in bold mixed case: if you do not store the provider information in mixed case you may print in all uppercase;
- Use black ink on white paper. Use shading as required by the instructions and exhibits;
- Print the front and back of the MSN at no more than 6 lines to the inch;
- Allow for coding necessary for mail sorting equipment (e.g., bar coding, aim marks); and
- Ensure any notations placed on the MSN for contractor use do not affect the design of the MSN.

Refer to the specifications and exhibits for placement of information on the MSN.

3726.4 TECHNICAL SPECIFICATIONS OF THE MSN

This information explains the display in specific areas of the notice and describes the technical specifications to be used in producing MSNs. The font should be consistent throughout the notice, and should be similar to the Times New Roman font. Use ½ inch outer margins on the notice.

General Information About Disclaimer:

- Near the bottom of the first page, print a 1 point line from the left to right margins.
- Below this line, equivalent to 15 point bold all caps, print `THIS IS NOT A BILL'
- Directly following this print equivalent to 15 point bold mixed case `Keep this notice for your records'.
- Print a bold dash between "THIS IS NOT A BILL" and "Keep this notice for your records" with a blank space on each side of the dash.
- This information should be centered.

3726.5 TITLE SECTION

A. General Information About the Title Section. This section contains a fixed display of information. It does not vary in length. It contains the following elements:

- HCFA Alpha Representation
- Title of notice
- Beneficiary's name and mailing address
- "Help Stop Fraud" statement
- Customer Service Information including:
  - beneficiary's Medicare number
  - contractor's mailing address
  - local telephone number
  - toll free telephone number, if available
  - TTY telephone number for the speech/hearing impaired, if available
- "Summary of claims processed" statement

B. Technical Specifications for Title Section. Details of the technical specifications for each element in §3726.5(A) follow.

- Title of Notice: Print the HCFA alpha representation in the upper left hand side, indented and printed within a box of 10% shading. A 1 point line surrounds the box. The box extends from the left margin to the right margin (width = 7.5 inches and height = .85 inches). The HCFA alpha representation is pulled from a Tiff file provided by HCFA.
- Print: "Medicare Summary Notice" in 30 point bold type. Center it within the remaining space of the box.
- In the top right hand corner of the title box, print "Page 1 of " in mixed case equivalent to 10 point type.
- In the bottom right hand corner of the title box, print the date the notice was printed in mixed case equivalent to 10 point type.
- Under the title box, leave a blank line equivalent to 12 point.

- Beneficiary's name and mailing address: Print the beneficiary's name and mailing address in all uppercase equivalent to 10 point size fixed pitch font (the font may not be script, italic or any other stylized font). Place the name and address information as shown in exhibits to conform to U.S. postal regulations. (The beneficiary's name and mailing address may be printed in fixed pitch fonts.)

NOTE: Do not change the format of the title section in order to use double window envelopes. Include a separate mailing sheet with both a return and delivery address for double window envelopes.

- Customer Service Information Box: Print a box equivalent to 1 point line around the following customer service information. Extend from center of page to the right margin. Height = 2 ½ inches and width = 3 ½ inches.

  -- Print "CUSTOMER SERVICE INFORMATIO N" in upper case equivalent to 12 point bold type.
  -- Equivalent to 12 point blank line.
  -- Indent four bytes and print "Your Medicare Number:" equivalent to 12 point bold mixed case.
  -- Equivalent to 12 point blank line.
  -- Print "If you have questions, write or call:" in mixed case equivalent to 12 point type.
  -- Indent 4 bytes and print the contractor's mailing address on the next five lines equivalent to 12 point type.
  -- Equivalent to 12 point blank line (there must be a blank line between the address and phone numbers)
  -- Indent 4 bytes and print "Local:" then your local telephone number to include area code, in mixed case equivalent to 12 point bold type.
  -- Indent 4 bytes and print "Toll free:" then your toll free telephone number in mixed case equivalent to 12 point bold type. If you do not have a toll free number, replace it with a 12 point blank line.
  -- Indent 4 bytes and print "TTY for Hearing Impaired:" then your TTY number in mixed case equivalent to 12 point type. If you do not have a TTY number, replace it with a 12 point blank line.

NOTE: You may list additional contact information, such as the phone number of the appeals department, in the Customer Service Information box (space permitting). All changes must be approved by the RO. The RO will notify CO of the approved changes.

- Print "HELP STOP FRAUD:" in upper case equivalent to 12 point bold type. Begin printing the fraud message on the same line as the heading. Print the fraud message in mixed case equivalent to 12 point type. It may continue for two additional lines. Fraud messages are found in this PM. Print only those messages approved for the 'Help Stop Fraud' section. The 'Help Stop Fraud' section should end no lower than the bottom of the Customer Service Information Box. There should be at least 2 bytes between the end of each line and the beginning of the Customer Service box.

- Equivalent to 12 point blank line.

- For all notices processed on multiple days print "This is a summary of claims processed from mm/dd/yyyy to mm/dd/yyyy." in mixed case equivalent to 14 point type centered between the margins. For all notices processed on a single day, print "This is a summary of claims processed on mm/dd/yyyy," in mixed case equivalent to 14 point type centered between the margins.

- Equivalent to 14 point blank line.

3726.6 CLAIMS INFORMATION SECTION

A. General Information About the Claims Information Section. The claims information section contains the following elements:

- -- Program status line ("Part A Hospital Insurance - Inpatient Claims " or "Part B Medical Insurance - Outpatient Facility Claims" or "Home Health Facility Claims" or "Part A - Hospice Facility Claims")
- -- Column headings
- -- Claim Number
- -- Provider's name and address
- -- Attending/referring physician's name
- -- Service line details
- -- Claim totals
- -- Alphabetic codes for "Notes"

The name and address of the billing provider includes the provider's name and complete mailing address. Below the billing provider's name and address, if applicable, show "Referred by," then give the full name of the attending physician.

- Claims should be displayed by billing provider in alphabetical order.

- For multiple claims from one billing provider, sort claims chronologically by date of service.

- Use standard abbreviation of Revenue Codes provided by the National Uniform Billing Committee. Do not change the wording. See §3604 of the MIM for standard abbreviations.

- If HCPCS are shown, use short description of services provided by HCFA. If the HCPC descriptor is used do not show the revenue code descriptor.

B. Technical Specifications for Claims Information Section. Details for the technical specifications for the claims information section listed in §3726.6(A) follow.

- Program Status Line: Print the program status line in uppercase equivalent to 12 point bold type. For inpatient claims, print "PART A HOSPITAL INSURANCE -INPATIENT CLAIMS." For outpatient claims, print "PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS." For home health claims print `HOME HEALTH FACILITY CLAIMS'. For hospice claims, print "PART A -HOSPICE FACILITY CLAIMS."

- Equivalent to 10 point blank line.

- Print a box equivalent to 1 point line around the following claims information. The box will be variable in length depending on the number of claims displayed. There is a 1 byte margin between the claims information box line and the beginning and ending of printed information. There is a 1 byte space between columns.

- Print the column headings in mixed case equivalent to 10 point bold type using three lines as in the exhibits.

  - -- “Dates of Service" - Use for all claims. The "Dates of Service" column is 17 bytes wide. Center the column heading within the first 7 bytes.

  - -- "Services Provided" - Use for outpatient and hospice claims. The "Services Provided" column is 45 bytes wide. Print the column heading flush left in the column.

- -- "Number of Services Provided" - Use for home health claims. The "Number of Services Provided" column is 45 bytes wide. Print the column heading flush left in the column.

- -- "Benefit Days Used" - Use for inpatient claims. The "Benefit Days Used" column is 11 bytes wide. Print the column heading flush right in the column.

- -- "Amount Charged" - Use for outpatient, home health and hospice claims. The "Amount Charged" column is 11 bytes wide. Print the column heading flush right in the column.

- -- "Non-Covered Charges" - Use for all claims. The "Non-Covered Charges" column is 11 bytes wide. Print the column heading flush right in the column.

- -- "Deductible and Coinsurance" - Use for inpatient, outpatient and hospice claims. - The "Deductible and Coinsurance" column is 10 bytes wide. Center the column heading.

- -- "Coinsurance" - Use for home health claims. The "Coinsurance" column is 10 bytes wide. Center the column heading.

- -- "You May Be Billed" - Use for all claims. The "You May Be Billed" column is 10 bytes wide. Center the column heading.

- -- "See Notes Section" - Use for all claims. The "See Notes Section" column is 7 bytes wide. Center the column heading.

- Print a horizontal line equivalent to 1 point extending from the left to right margin between the column headings and the claim(s) information.

- Equivalent to 10 point blank line.

Print claim information within the box as follows: Print the following information on the appropriate MSNs, as listed above.

- The claim number spans the "Dates of Service" and "Services Provided" columns. Do not extend information into the `Amount Charged' column.

  - -- Print "Claim number" in mixed case equivalent to 10 point followed by the actual claim number on the line directly above the provider's name and address.

- The provider information spans the "Dates of Service" and "Services Provided" columns. Do not extend information into the "Amount Charged" column.

  - -- Print the billing provider's name and mailing address in mixed case equivalent to 10 point bold type. (If you do not store the provider information in mixed case you may print it in uppercase.) The billing provider name and address should be separated by commas. Use the physical address of the billing provider if it is different from the mailing address. If possible, print this information on one line. Additional lines, if necessary, should be indented 5 bytes.

  - -- Print "Referred by:" followed by the attending physician's name and degree (if applicable) in mixed case equivalent to 10 point type. When printing degree (i.e., M.D.) with provider's name, place a period after the "M" and after the "D." Referring physician's name and degree should be separated by a comma. If the UPIN submitted on the claim is not on your file, use the name as shown on the claim. Suppress the "Referred by" line if not able to identify the doctor.

- "Dates of Service" - Print service line dates in mm/dd/yy format in "Dates of Service" column in mixed case equivalent to 10 point type. Left justify. If services extend over several days, use a hyphen/dash to show the extension (mm/dd/yy -mm/dd/yy).

- "Services Provided" - The "Services Provided" column contains the HCPCS short descriptor in mixed case equivalent to 10 point type followed by the code in parenthesis or revenue code descriptor. If no HCPCS code is present, show the revenue code standard abbreviation as defined by the National Uniform Billing Committee. Left justify (bytes 1-45 are reserved for these descriptions). Print each service description in no more than one line, on the same line horizontally as the `Date of Service'.

- "Number of Services Provided" - The "Number of Services Provided" column contains the revenue code standard abbreviation as defined by the National Uniform Billing Committee, preceded by the number of units, both of which are in mixed case equivalent to 10 point type. If a HCPC code is present, the HCPC's short descriptor will be shown. Left justify (bytes 1-45 are reserved for this element). Print each "Number of Services Provided" in no more than one line, on the same line horizontally as the "Date of Service".

- "Benefit Days Used" - The "Benefit Days Used" column will show the number of covered days used during the hospital or skilled nursing facility admission (i.e. 12 days) in mixed case equivalent to 10 point type. Left justify (bytes 1-11 are reserved for this element). Print each "Benefit Days Used" in no more than one line, on the same line horizontally as the "Date of Service".

- Align all dollar amounts appearing in the "Claim Information Box" by decimal. For zero dollar amounts, show "0.00." Print all dollar amounts in mixed case equivalent to 10 point type.

- "Amount Charged" - Show the submitted charge for each service line. Print a dollar sign on the first service line. Right justify all charges.

- "Non-Covered Charges" - Show the noncovered amount for each service line. Print a dollar sign on the first service line. Right justify all charges. Non-covered services will include beneficiary liable as well as provider liable charges.

- "Deductible and Coinsurance" - Show the "Deductible and Coinsurance" applicable for each service line. Print a dollar sign on the first service line. Right justify all amounts.

- "Coinsurance" - Show the "Coinsurance" applicable for each service line. Print a dollar sign on the first service line. Right justify all amounts.

- “You May Be Billed" - Show the beneficiary liability for each service line as shown in §3726.10. Print a dollar sign on the first service line. Right justify all amounts.

- "See Notes Section" - Enter a lowercase "a," equivalent to 10 point type, for the first item which requires an explanation. Place "a" and the appropriate message from §3726.21(A) in the "Notes Section" box. If the same message is needed for more than one claim or service line, print the same alphabetic code each time the message is required on the MSN.

    - If your system provides a second message for the same item, print the letter "b" in lowercase equivalent to 10 point type preceded by a comma. Show no more than 6 alphabetic codes per line.

    - For all remaining claims on the MSN, if a claim or service line requires a message, use the next available lowercase alphabetic code.

    - Print up to 6 alphabetic codes for claim level notes in bold in the "See Notes Section" column on the same line as the billing provider's name, the next 3 will be directly below the first 3, which would make them on the same line as the billing provider's street address.

-- Print alphabetic codes for service lines in the "See Notes Section" column on the same line as the service. If there are more than three alphabetic codes on the line level, print on the next line below.

-- Print alphabetic codes flush left.

-- If more than 26 lowercase alphabetic codes are used, begin using uppercase alphabetic codes.

· "Claim Total" line - Indent 12 bytes and print in mixed case type equivalent to 10 point bold, "Claim Total." Print the "Claim Total" line only for claims with more than one service line.

-- Total the amounts in each column and print the sum right justified, equivalent to 10 point bold type. Print a dollar sign preceding the total in each column.

· Print a horizontal line 1/16 inch wide in 20% shading extending from left to right margin on the claim information box. Print this shaded line between each claim shown on the MSN. Do not print the shaded line under the last claim displayed in the Claims Information Section. Do not print the shaded line if only one claim is displayed on the MSN.

· Additional Claims Information Specifications:

-- Split a claim between pages if the claim is more than 10 lines long. You must be able to print at least 5 lines or don"t split the claim; rather, put the claim on the next page.

-- If there is a need to continue the Claim Information Box past the first page, print the program status line on the top of continuing pages in the upper left corner below the header, followed by "(continued)," equivalent to 12 point bold lower case type.

-- Repeat column headings and line specifications according to the preceding instructions.

-- Allow one equivalent to 12 point blank line between claims information and beginning of notes section.

-- You may split an MSN if more than 99 claims were processed in one 31 day period.

3726.7 MESSAGE SECTION

A. General Information about Messages Section. The Message Section consists of three parts:

· The **Notes Section** contains alphabetic codes and messages explaining the claim and service line determinations.

· **Deductible Information** contains messages communicating deductible status for each year of service or benefit period displayed on the MSN.

· **General Information** contains news of general interest that is issued to all beneficiaries.

B. Technical Specifications for Message Section. The following outlines the technical specifications for each element of the Message Section:

· **Notes Section**

-- Print a box equivalent to 1 point line around the Notes Section.

- -- The length of the Notes Section varies depending on the number of messages needed. If there are no messages to be printed, suppress the entire Notes Section.
- -- Allow a 1 byte margin between the Notes Section box line and the beginning and ending of printed information.
- -- Indent one byte and print "Notes Section:" title in mixed case equivalent to 14 point bold type.
- -- Equivalent to 12 point blank line.
- -- Indent the alphabetic code(s) 2 bytes from the margin.
- -- List the message codes in alphabetic order.
- -- Print the first 26 alphabetic codes in lower case equivalent to 12 point type. Print additional alphabetic codes in upper case equivalent to 12 point type. Print all the messages in mixed case equivalent to 12 point type.
- -- Allow 2 bytes between the alpha code and the message.
- -- Indent additional lines of each message 5 bytes from the margin.
- -- Allow one equivalent to 12 point blank line between messages.
- -- Do not print the "Notes Section" title without at least one complete message following it on the same page.
- -- Do not split messages. Each message must be printed in its entirety on the same page.
- -- Print "(continued)" equivalent to 12 point bold type in the bottom right corner of the "Notes Section" box when the Notes Section continues onto another page.
- -- Print the title "Notes Section (continued):" in mixed case equivalent to 14 point bold type in the upper left corner of the next page below the header.
- -- All Notes Section boxes should be closed on each page that they appear.
- -- Allow one equivalent to 12 point blank line between Notes Section and Deductible Information.

- **<u>Deductible Information</u>**

  - -- Print "Deductible Information" title in mixed case equivalent to 14 point bold type.
  - -- Equivalent to 12 point blank line.
  - -- Indent 3 bytes and print deductible messages in mixed case equivalent to 12 point type.
  - -- Suppress the "Deductible Information" section if there is no record of entitlement for the beneficiary, or denial.
  - -- Print the appropriate deductible message(s) from the Deductible/Coinsurance section of §3726.21(A)(37).
  - -- Multiple deductible messages should appear for outpatient MSNs if multiple calendar years of service are displayed on the MSN, and for inpatient MSNs if multiple benefit periods appear. Print messages in chronological order by year.

If message 37.10 applies to multiple inpatient claims on the same MSN, list it only once in the deductible section.

-- Do not split the "Deductible Information" section. There will in most cases be only one message printed here. If you cannot print the title and all deductible messages on one page, print all information on the next page.

-- If there are more than one deductible messages, allow equivalent to 12 point blank line between each.

-- Allow two equivalent to 12 point blank lines between the last line of the "Deductible Information" section and the "General Information" title.

-- Suppress the "Deductible Information" section if the MSN contains only home health claims, SNF claims, and/or hospice claims, since there are no deductibles for these claims. If other claims appear on the MSN, for which there is a deductible, then print the "Deductible Information" section.

· **General Information**

-- Print "General Information" title in mixed case equivalent to 14 point bold type.

-- Equivalent to 12 point blank line.

-- Indent 3 bytes from the margin and print "General Information" messages in mixed case equivalent to 12 point type.

-- Suppress the "General Information" section if there are no messages to print.

-- Do not print the "General Information" title without at least one complete message following it on the same page.

-- Do not split messages. Each message must be printed in its entirety on the same page.

-- Allow one equivalent to 12 point blank line between messages.

-- Print the title "General Information (continued)" in mixed case equivalent to 14 point bold type in the upper left corner of the next page below the header when information continues to another page.

-- Messages for "General Information" should be clear, concise and relevant. Submit proposed messages to your RO for approval. The RO will determine the appropriate length of time to display each message.

-- Allow two equivalent to 12 point blank lines between the last line of "General Information" and the "Appeals Information" title.

3726.8 APPEALS SECTION

A. General Information about the Appeals Section. This section informs the beneficiary of his/her appeal rights. Only print Part B medical insurance language if only outpatient information is on the MSN or Part A Hospital information if only inpatient information is on the MSN. Print both Part A and B appeals language side by side if both claim types are on the MSN.

B. Technical Specifications. The following outlines the technical specifications for the Appeals section.

- The "Appeals Section" must be printed in its entirety. Display it at the bottom of the last page of the MSN if space permits. Otherwise, print it in its entirety at the top of the next page (which then becomes the last page).

- For Part A Appeals:

  -- Print "Appeals Information - Part A (Inpatient)" in mixed case equivalent to 14 point bold type

  -- Equivalent to 12 point blank line

  -- Print "If you disagree with any claims decision on this notice, you can request an appeal by (appeal date). Follow the instructions below:" in mixed case equivalent to 12 point type, flush left. Bold the following words/phrases: "If you disagree with any claims decision on this notice" and the appeals date.

  -- The Part A appeals date is 60 days from the notice date on Page 1. Date format is month, day, year (i.e. October 1, 1999).

  -- Equivalent to 12 point blank line

- For Part B Appeals:

  -- Print "Appeals Information - Part B (Outpatient)" in mixed case equivalent to 14 point bold type

  -- Equivalent to 12 point blank line

  -- Print "If you disagree with any claims decision on this notice, you can request an appeal by (appeal date). Follow the instructions below:" in mixed case equivalent to 12 point type, flush left. Bold the following words/phrases: "If you disagree with any claims decision on this notice" and the appeals date.

  -- The Part B appeals date is 6 months from the notice date on Page 1. Date format is month, day, year (i.e. October 1, 1999).

  -- Equivalent to 12 point blank line

- For Part A and Part B Appeals on the same MSN:

  -- Print "Appeals Information - Part A (Inpatient)" in mixed case equivalent to 14 point bold type, flush left, on one half of the page. On the same line, flush right, print "Appeals Information - Part B (Outpatient)" in mixed case equivalent to 14 point bold type, flush right.

  -- Equivalent to 12 point blank line

  -- Print "If you disagree with any claims decision on PART A of this notice, you can request an appeal by (appeal date)." in mixed case equivalent to 12 point type, flush left. Bold the following words/phrases: "If you disagree with any claims decision on PART A of this notice" and the appeals date. The words "PART A" should be all caps.

  -- On the same line, print "If you disagree with any claims decision on PART B of this notice, you can request an appeal by (appeal date)." in mixed case equivalent to 12 point type, on the right side of the page. Bold the following words/phrases: "If you disagree with any claims decision on PART B of this notice" and the appeals date. The words "PART B" should be all caps.

-- Equivalent to 12 point blank line

-- Print, centered between the two portions, "Follow the instructions below:"

-- Equivalent to 12 point blank line

. For all appeals (Part A, Part B or combined)

Format each of the following three lines by indenting 11 bytes, and writing a number followed by a parenthesis, skipping two additional bytes, and writing the text. Allow one equivalent to 12 point blank line between each printed line. Print all information equivalent to 12 point mixed case type. This information should only be shown once and centered if both Part A and B appeals language is shown.

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1.

3) Sign here Phone number ( )

3726.9 CONTINUATION PAGE

A. General Information about the Continuation Page. For MSNs that cannot be printed on one page, use a continuation page heading for page two and subsequent pages of the MSN. The heading contains the following:

· ½ inch margin

· Beneficiary's Medicare Number

· "Page of "statement

· Date of Notice

· Equivalent to two 12 point blank lines

· Remainder of MSN

B. Technical Specifications for a Continuation Page. Use the following specifications to produce headings for subsequent pages of the MSN.

· Print "Your Medicare Number: "flush left equivalent to 12 point bold mixed case type.

· Print "Page of "flush right equivalent to 10 point mixed case type on the same line as "Your Medicare Number".

· Print date of notice flush right equivalent to 10 point type directly under "Page of ."Date format is month, day, year (i.e., October 1, 1997).

· Allow two 12 point blank lines between the heading of the continuation page and the remaining portion of the MSN.

3726.10 MSN CALCULATIONS

This section provides calculations for correctly displaying dollar amounts in certain columns of the MSN.

A. "You May Be Billed" Column. The following chart is to be used to display the "You May Be Billed" amounts for each service line on outpatient claims other than those which have 1) a Medicare secondary payment less than the amount Medicare would have paid if it were primary and 2) a beneficiary paid amount.

Calculations for Completing "You May Be Billed" Column – Outpatient Claims	**Instructions/Source of Dollar Amount for Calculations**
A. Service line billed amount	This is the service line billed amount. This amount should be shown in the "Amount Charged" column of the MSN.
B. Psychiatric reduction	B = A x 37.5% This is applicable only to services subject to the outpatient mental health treatment limitation. For all other services, B = 0.
C. Amount remaining after psychiatric reduction	C = A – B
D. Deductible applied	This is the amount of deductible applied on the service line. If no deductible applied, D = 0
E. Amount charged less deductible	E = C – D
F. Less Medicare co-payment amount	F = E x .20 Services paid at 100% of the approved amount do not have a co-payment. For services paid at 100%, F = 0.
G. Amount after deductible, coinsurance and psychiatric reduction.	G = E – F
H. Of the billed amount.	This is dollar amount shown in "A"
I. Less what Medicare owes	This is the dollar amount shown in "G"
J. Net responsibility	J = H – I
K. Plus non-covered Medicare charges.	This step represents charges that Medicare does not cover shown in the "Non-Covered Charges" column on the MSN. Charges for which the beneficiary is determined to have no liability for should be excluded from this step. Exclude dollar amounts for denials such as Services determined not to be medically necessary and the beneficiary was not informed in writing, in advance, that the services may not be paid; Missing information such as ICD-9, UPIN, etc.; The charge was denied as a duplicate; The service was part of a test panel; The service was denied/reduced because of utilization reasons.
L. Beneficiary responsibility	L = J + K Display this amount in the "You May Be Billed" column for service lines on outpatient claims. Claims submitted with a beneficiary paid amount require additional calculations, therefore, proceed to step section C.

B. **Display of the "You May Be Billed" Column for MSP Claims.** If the Medicare secondary payment plus the amount the primary insured paid equals or exceeds what Medicare would have paid, the "You May Be Billed" column for each approved service should display $0.00.

If the primary insurer paid amount is less than what Medicare would have paid, the amount shown in "You May Be Billed" column for each service line needs to be reduced using the following formula. For the first service line:

- Amount you may be billed = [(deductible + coinsurance) - primary paid amount] + non-covered charges.
- For the second service line the same formula would be followed with the primary amount equaling the primary paid minus the deductible + coinsurance from the first line.

Continue in this manner until either the primary paid amount equals $0.00 or the deductible + coinsurance equals $0.00.

Example 1: On this claim the Medicare payment would have been $2172.54. The primary insurer paid $2400.00, and $543.14 would have been applied to coinsurance.

Services Provided	Amount Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Sick Hospital, 123 West Street					**a**
Wellness, TX 75256					
Referred by : John Smith, M.D.					
Dialysis Procedure (90999)	$2,715.68		$00.00	$543.14	$00.00

Note: a Your primary group's payment satisfied Medicare deductible and coinsurance.

Example 2: On this claim the Medicare payment would have been $700.00. $100 was applied to the deductible and $100 was applied to the coinsurance. The primary insurer paid $800.00.

Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Sick Hospital, 456 Sick Ln					**a**
Wellness, TX 75256					
Referred by : John Apple, M.D.					
Panel, not specified (80099)	$300.00	$00.00	$00.00	$00.00	
Nuclear Medicine Therapy (79999)	600.00	00.00	100.00	00.00	
Claim Total	**$900.00**	**$00.00**	**$100.00**	**$00.00**	

Note: a Your primary group's payment satisfied Medicare deductible and coinsurance.

Example 3: On this claim the Medicare payment would have been $525.00. $100 was applied to the deductible and $205.00 to the coinsurance. The primary insurer paid $550.00. (Since it"s not clear from the paid amount whether the take home drugs were paid, it must show as "You May Be Billed".)

Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Well Hospital, 123 Well Ln					**a**
Secondary, TX 75123					
Referred by: John Sick, M.D.					

Pharmacy	$80.00	$0.00	$80.00	$0.00	
Take Home Drugs	20.00	20.00	0.00	20.00	b
Prosthetics/Orthotic (L3800)	150.00	0.00	46.00	0.00	
Medical/Surgical Supplies	50.00	0.00	10.00	0.00	
Culture (87117)	30.00	0.00	0.00	0.00	c
X-Ray (71020)	45.00	0.00	9.00	0.00	
Bronchoscopy (31622)	500.00	0.00	100.00	0.00	
Anesthesia	200.00	0.00	40.00	0.00	
Immunization (90732)	20.00	0.00	0.00	0.00	c
EKG (93005)	100.00	0.00	20.00	0.00	
Vaccine Administration (G0009)	15.00	0.00	0.00	0.00	c
Claim Total	**$1,210.00**	**$20.00**	**$305.00**	**$20.00**	

Notes: a Your primary group's payment satisfied Medicare deductible and coinsurance.
b Medicare does not pay for this item or service.
c This service is paid at 100% of the Medicare approved amount.

B. Display of the "You May Be Billed" Column for Claims Submitted with a Beneficiary Paid Amount:

- If a claim is submitted with a beneficiary paid amount, the amount(s) in the "You May Be Billed" column will be reduced by the amount the beneficiary pre-paid the provider.
- Apply the beneficiary paid amount to each service line sequentially until the beneficiary paid amount is reduced to zero or all service lines have been considered.
- Step 1: If the amount the beneficiary paid is less than or equal to the amount shown for the "You May Be Billed" column, subtract the amount the beneficiary paid from that amount and display the difference in the "You May Be Billed" column for that service line.
- Step 2: If the amount the beneficiary paid is greater than the amount calculated for the "You May Be Billed" column, subtract the "You May Be Billed" amount for the first service line from the amount the beneficiary paid and show zero in the "You May Be Billed" column.
- If the beneficiary made a payment on a claim, subtract the amount of the beneficiary's reimbursement, if any, from the amount the beneficiary paid. Use that amount to reduce the "You May Be Billed" column.
- Repeat these steps with any remaining beneficiary paid amounts. If there is a balance after all services lines have been considered, that amount should match the check amount to the beneficiary on that claim. If payment was made to the beneficiary, balance should be shown in the appropriate blank of message 34.4. If beneficiary paid amount does not result in the issuance of a check, print message 34.2.

Example 1: On this claim the beneficiary paid $75.00.

Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Sick Hospital, 123 West Street Jacksonville, FL 32231					**a**
Referred by : John Smith, M.D.					
Dialysis	$367.68	$00.00	$73.53	$00.00	

Note: a We are paying you $1.47 because the amount you paid the provider was more than you may be billed.

3726.11 BACK OF THE MSN

A. General Information about the Back of the MSN.

- Print the appropriate information on the back of each page of the MSN. The information may be preprinted.
- Print the back of the MSN at no more than 6 lines to an inch.

B. Technical Specifications for the Back of the MSN.

Technical Specifications for the Back of the MSN. The text for the back of the MSN is provided in Exhibit 2. Use the following specifications:

- Title: "IMPORTANT INFORMATION YOU SHOULD KNOW ABOUT YOUR MEDICARE BENEFITS", centered, in upper case equivalent to 14 point bold type in a band of 10% shading.
- Equivalent to 12 point blank line.
- Subtitle: "For more information about services covered by Medicare, please see your Medicare Handbook.", centered and printed equivalent to 14 point mixed case type.
- Horizontal line (0.048" wide extending from left to right margin).
- Equivalent to 12 point blank line.
- Print the language, as shown in Exhibit 2, single spaced in two newspaper style columns equivalent to 11 point mixed case type.
- Print a line down the center of the page dividing the two columns as shown in exhibit 2.
- In the following paragraphs of exhibit 2, print the indicated words in bold type and, where capitalized in this section, in all caps:
    - -- Paragraph 1 - "PART A HOSPITAL INSURANCE (INPATIENT)"
    - -- Paragraph 2 - "THE AMOUNT YOU MAY BE BILLED"; "Part A"; "an inpatient hospital deductible"; "a coinsurance amount for the 61st through 90th days"; "a coinsurance amount for each Lifetime Reserve Day"; "a blood deductible"; "an inpatient coinsurance for the 21st through the 100th days"; "skilled nursing facility"; "not covered". The word "NOTE" should be all caps but not bolded.
    - -- Paragraph 3 - "PART B MEDICAL INSURANCE (OUTPATIENT FACILITIES)"
    - -- Paragraph 4 - "THE AMOUNT YOU MAY BE BILLED"; "Part B"; "annual deductible"; "$100"; "a coinsurance amount"; "not covered."
    - -- Paragraph 6 - "WHEN OTHER INSURANCE PAYS FIRST:"
    - -- Paragraph 7 - "YOUR RIGHT TO APPEAL:" "PART A"; "60 days"; "PART B", "6 months"; "help with your appeal."
    - -- Paragraph 8 - "HELP STOP MEDICARE FRAUD:"
    - -- Paragraph 9 - "INSURANCE COUNSELING AND ASSISTANCE:"
- Blank line.
- Horizontal line (0.048" wide extending from left to right margin).

- Print "Health Care Financing Administration" equivalent to 10 point bold italic type, centered in a band of 10% shading.

3726.12 SEPARATE LINE ITEMS

In the following situations, provide separate line items on the MSN:

- The same services were provided by the same provider, but the billed amounts are not all covered.
- The same services were provided by the same providers, but the denial or reduction reasons are not the same for each service.

3726.13 SUPPRESSION OF CLAIMS FROM MSNs

You have the option to suppress claims from MSNs when all of the following three conditions apply:

- The claim is a coordination of benefits (crossover) claim for Medicaid;
- There is no resulting beneficiary liability; and,
- Suppression of the MSN is cost effective.

In addition, if your system denies an exact duplicate of a claim, the claim will be suppressed from the MSN. An exact duplicate claim is one in which every field of the duplicate claim matches every field of the original claim.

Since appeal rights are not affected, do not display claims on MSNs for services paid at 100 percent of the fee schedule where no deductible or coinsurance is applied, e.g. diagnostic laboratory services. If other services on that claim will appear on the MSN, include all services being paid.

Upon beneficiary's request, create and send MSNs for previously suppressed claims.

Do not suppress claims from MSNs when any of the following conditions apply:

- One or more services is denied because one of the exclusions from Medicare coverage in §1862(a)(1) of the Social Security Act (the Act) applies;
- The claim is denied as not filed within the time limits required by §1842(b)(3) of the Act;
- The claim is denied in full or in part because the beneficiary was not enrolled in Part A or B of Medicare when the services in question were provided; or
- An initial determination, whether favorable or unfavorable, is made on a claim 60 days or more after its receipt.

3726.14 SPANISH MSN

A. Specifications for the Spanish MSN. The Spanish MSN should be developed using the same specifications for the English MSN. The actual text of the MSN will be in Spanish. Translations for the Spanish MSN are as follows. Some modifications to your page definitions, form definitions and print programs may be necessary to allow for the Spanish text.

Disclaimer Section:

ENGLISH- THIS IS NOT A BILL
SPANISH- Esta Notificación No es Una Factura
ENGLISH - Keep this notice for your records.
SPANISH - Retenga esta notificación para sus archivos.

3726.15 TITLE SECTION

ENGLISH - Page ( ) of ( )
SPANISH - Página ( ) de ( )
ENGLISH - Medicare Summary Notice
SPANISH - Resumen de Medicare
ENGLISH - Your Medicare Number:
SPANISH - Su Número de Medicare:
ENGLISH - CUSTOMER SERVICE INFORMATION
SPANISH - INFORMACION DE SERVICIOS AL CLIENTE
ENGLISH - If you have questions, write or call:

SPANISH - Si usted tiene preguntas, escriba o llame a:
ENGLISH - Local:
SPANISH - Local:
ENGLISH - Toll-free:
SPANISH - Libre de cargos:
ENGLISH - TTY for Hearing Impaired:
SPANISH - TTY Impedimento Auditivo:
ENGLISH - HELP STOP FRAUD
SPANISH- Ayude a Detener el Fraude
ENGLISH - This is a summary of claims processed from ( ) through ( ).
SPANISH - Este es un resumen de reclamaciones procesadas desde ( ) hasta ( ).
ENGLISH - This is a summary of claims processed on ( ).
SPANISH - Este es un resumen de reclamaciones procesadas el ( ).

3726.16 CLAIMS INFORMATION SECTION

ENGLISH - PART A HOSPITAL INSURANCE - INPATIENT CLAIMS
SPANISH - PARTE A SEGURO DE HOSPITAL - Reclamaciones de Paciente Interno
ENGLISH - PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS
SPANISH - PARTE B SEGURO MEDICO - Reclamaciones de Facilidades de Paciente Externo
ENGLISH - HOME HEALTH FACILITY CLAIMS
SPANISH - Reclamaciones de Facilidades de Servicios en el Hogar
ENGLISH- PART A - HOSPICE FACILITY CLAIMS
SPANISH - PARTE A - Reclamaciones de Facilidades de Hospicio
ENGLISH - Claim number
SPANISH - Reclamación número
ENGLISH- Dates of Service
SPANISH - Fechas de Servicio
ENGLISH - Services Provided
SPANISH- Servicios Proporcionados
ENGLISH - Number of Services Provided
SPANISH - Número de Servicios Proporcionados
ENGLISH - Benefit Days Used
SPANISH - Días de Beneficios Usados
ENGLISH - Amount Charged
SPANISH- Cargos
ENGLISH - Noncovered Charges
SPANISH - Cargos No Cubiertos
ENGLISH - Deductible and Coinsurance
SPANISH - Deducible y Coaseguro
ENGLISH - Coinsurance
SPANISH - Coaseguro
ENGLISH- You May Be Billed
SPANISH- Podría Ser Facturado
ENGLISH - See Notes Section
SPANISH- Vea las Notas
ENGLISH - Claim Total
SPANISH - Reclamación Total

ENGLISH - Referred by:
SPANISH - Referido por:

3726.17 MESSAGE SECTION

ENGLISH - Notes Section:
SPANISH - Sección de Notas:
ENGLISH - Notes Section (continued):
SPANISH - Sección de Notas (continuación):
ENGLISH- Deductible Information:
SPANISH- Información de Deducible:

ENGLISH- General Information:
SPANISH - Información General:
ENGLISH - General Information (continued):
SPANISH- Información General (continuación)

3726.18 APPEALS SECTION

ENGLISH - Appeals Information - Part A (Inpatient)
SPANISH - Información de Apelaciones - Parte A (Paciente Interno)
ENGLISH - Appeals Information - Part B (Outpatient)
SPANISH - Información de Apelaciones - Parte B (Paciente Externo)
ENGLISH- If you disagree with any claims decision on this notice, you can request an appeal by ( ). Follow the instructions below:
SPANISH - Si usted no está de acuerdo con cualquier decisión tomada en esta notificación, usted puede apelar en o antes de ( ). Siga las instrucciones indicadas abajo:
ENGLISH- If you disagree with any claims decision on Part A of this notice, you can request an appeal by ( ).
SPANISH - Si usted no está de acuerdo con cualquier decisión tomada en esta notificación, usted puede apelar en o antes de ( ).
ENGLISH - If you disagree with any claims decision on Part B of this notice, you can request an appeal by ( ).
SPANISH - Si usted no está de acuerdo con cualquier decisión tomada en esta notificación, usted puede apelar en o antes de ( ).
ENGLISH - Follow the instructions below:
SPANISH - Siga las instrucciones indicadas abajo:
ENGLISH - Circle the item(s) you disagree with and explain why you disagree.
SPANISH - Indique con un círculo los detalles con los que usted no está de acuerdo y explique la razón.
ENGLISH- Send this notice, or a copy, to the address in the Customer Service Information box on page 1.
SPANISH - Envíe esta notificación o una copia a la dirección indicada en la sección Información de Servicios al Cliente en la página 1.
ENGLISH - Sign here Phone Number ( )
SPANISH - Firme aquí Su número de teléfono ( )

3726.19 TEXT and SPECIFICATIONS FOR SPANISH MSN BACK

The Spanish back should be printed using the same specifications as the English version. However, the font size is 10 point. Use the text provided in the Spanish MSN exhibit.

In the following paragraphs of exhibit 2, print the indicated words in bold type and, where capitalized in this section, in all caps:

- paragraph 1 - SEGURO DE HOSPITAL PARTE A (PACIENTE INTERNO), La cantidad por la cual usted podría recibir una factura incluye:

  -- un deducible de paciente interno en un hospital
  -- una cantidad de coaseguro por los días 61 hasta 90

-- una cantidad de coaseguro por cada Día de Reserva Vitalicia
-- un deducible de sangre
-- un coaseguro de paciente interno por los días 21 hasta 100, facilidad de enfermería especializada,
-- no están cubiertos

· paragraph 2 - SEGURO MEDICO PARTE B (PACIENTE EXTERNO), La cantidad por la cual usted podría recibir una factura incluye:

-- un deducible anual,
-- un coaseguro

-- no están cubiertos

· paragraph 3 - CUANDO OTRO SEGURO PAGA PRIMERO:

· paragraph 4 - SU DERECHO A APELAR:, 60 días, 6 meses, ayuda con su apelación

· paragraph 5 - AYUDE A DETERNER EL FRAUDE A MEDICARE:

· paragraph 6 - CONSEJERIA Y ASISTENCIA DE SEGURO:

3726.20 EXHIBITS

The following exhibits show the MSN format, the back of the notice and selected displays. They provide a reference point for use in generating the format of the MSN. The data displayed in the exhibits is for illustration purpose only.

Exhibit 1 Inpatient/Outpatient Combined

Exhibit 2 Back of Notice

Exhibit 3 Outpatient Psychiatric Services

Exhibit 4 Deductible Applied

Exhibit 5 Noncovered Service (Beneficiary is Liable.)

Exhibit 6 Split Pay Claim, Patient Paid, 100% Services

Exhibit 7 MSP Situations

Exhibit 8 MSP with Noncovered Charge

Exhibit 9 MSP -- Cost Avoided

Exhibit 10 MSP -- Partial Recovery - Beneficiary has some liability remaining.

Exhibit 11 MSP--Full Recovery - Beneficiary has no liability remaining.

Exhibit 12 Home Health

Exhibit 13 Hospice

Exhibit 14 Spanish Inpatient/Outpatient Combined

Exhibit 15 Spanish Back of Notice

3726.21 EXPLANATORY AND DENIAL MESSAGES

The purpose of the following MSN messages is to concisely communicate essential information to the beneficiary regarding claim determinations or to serve as an educational tool.

Messages are grouped in categories for ease of reference only. Contractors should use the most appropriate message(s) for each situation and are not limited to messages within specific categories. The message numbering in this section does not have to be used in contractor message generating systems, nor is the usage of messages restricted to the titled categories if the messages are appropriate for use in other situations.

Use the most appropriate message to explain the action taken on a service, item or claim. Messages are grouped for ease of use/reference only and do not determine workload reporting. Contractors are instructed to use the most appropriate message for each situation regardless of message category.

Use multiple messages as appropriate including ones grouped within different categories. Use the message(s) which best explains the situation in the claim.

All denied or reduced services must have an explanation; however, covered services do not require a message.

You may combine "add-on" messages with existing messages to create a single message within your file.

Each message on your file is tied to an alphabetic code on the MSN. Print no more than three alphabetic codes per claim level and three alphabetic codes per service line.

Messages containing fill-in blanks may be left as blanks for filling in by the system or may be entered into the contractor system with blanks pre-filled to create as many specific messages as there are fill-in situations.

Certain messages are mandated due to the format of the MSN. These messages are annotated in the following sections. In addition, for ease of reference, a compilation of mandated messages can be found in §3726.14(A)(40). This does not eliminate the need to use other messages required by instructions elsewhere in the manual.

Beneficiary liability "add-on" messages should be printed in addition to denial and reduction messages for charges which the beneficiary is determined not liable. Liability "add-on" messages should print for denials/reductions such as:

- Services which are part of another service or bundled code;
- Services determined not to be medically necessary in situations where the beneficiary was not notified in writing, prior to receipt of the service, that Medicare may not make payment;
- Duplicate charges;
- Denials for utilization reasons.

3726.21A SECTIONS SHOWING APPROVED MESSAGES FOR THE MSN

1 Ambulance
2 Blood
3 Chiropractic
4 End-Stage Renal Disease (ESRD)
5 Name/Number/Enrollment
6 Drugs
7 Duplicates
8 Durable Medical Equipment (DME)

9 Failure to Furnish Information
10 Foot Care
11 Transfer of Claims or Parts of Claims
12 Hearing Aids
13 Skilled Nursing Facility
14 Laboratory
15 Medical Necessity
16 Miscellaneous
17 Non Physician Services
18 Preventive Care
19 Hospital Based Physician Services
20 Benefit Limits
21 Restrictions to Coverage
22 Split Claims
23 Surgery
24 Fraud and Abuse (Help Stop Fraud)
25 Time Limit for Filing
26 Vision
27 Hospice
28 Mandatory Assignment for Physician Services Furnished For Medicaid Patients
29 Medicare Secondary Payer (MSP)
30 Reasonable Charge and Fee Schedule
31 Adjustments
32 Overpayments/Offsets
33 Ambulatory Surgical Centers
34 Patient Paid/Split Payments
35 Supplemental Coverage/Medigap
36 Limitation of Liability
37 Deductible/Coinsurance
38 General Information
39 Add-on Messages
40 Mandated Messages
41 Home Health
60 Demonstration Projects

AMBULANCE

1.1 - Payment for transportation is allowed only to the closest facility that can provide the necessary care.

1.2 - Payment is denied because the ambulance company is not approved by Medicare.

1.3 - Ambulance service to a funeral home is not covered.

1.4 - Transportation in a vehicle other than an ambulance is not covered.

1.5 - Transportation to a facility to be closer to home or family is not covered.

1.6 - This service is included in the allowance for the ambulance transportation.

1.7 - Ambulance services to or from a doctor's office are not covered.

1.8 - This service is denied because you refused to be transported.

1.9 - Payment for ambulance services does not include mileage when you were not in the ambulance.

1.10 - Air ambulance is not covered since you were not taken to the airport by ambulance.

1.11 - The information provided does not support the need for an air ambulance. The approved amount is based on ground ambulance.

BLOOD

2.1 - The first three pints of blood used in each year are not covered.

2.2 - Charges for replaced blood are not covered.

CHIROPRACTIC

3.1 - This service is covered only when recent x-rays support the need for the service.

ESRD

4.1 - This charge is more than Medicare pays for maintenance treatment of renal disease.

4.2 - This service is covered up to (insert appropriate number) months after transplant and release from the hospital.

4.3 - Prescriptions for immunosuppressive drugs are limited to a 30-day supply.

4.4 - Only one supplier per month may be paid for these supplies/services.

4.5 - Medicare pays the professional part of this charge to the hospital.

4.6 - Payment has been reduced by the number of days you were not in the usual place of treatment.

4.7 - Payment for all equipment and supplies is made through your dialysis center. They will bill Medicare for these services.

4.8 - This service cannot be paid because you did not choose an option for your dialysis equipment and supplies.

4.9 - Payment was reduced or denied because the monthly maximum allowance for this home dialysis equipment and supplies has been reached.

4.10 - No more than ($) can be paid for these supplies each month. (NOTE: Insert appropriate dollar amount.)

4.11- The amount listed in the "You May Be Billed" column is based on the Medicare approved amount. You are not responsible for the difference between the amount charged and the amount charged and the approved amount.

NAME / NUMBER / ENROLLMENT

5.1 - Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office.

5.2 - The name or Medicare number was incorrect or missing. Please check your Medicare card. If the information on this notice is different from your card, contact your provider.

5.3 - Our records show that the date of death was before the date of service.

5.4 - If you cash the enclosed check, you are legally obligated to make payment for these services. If you do not wish to assume this obligation, please return this check.

5.5 - Our records show you did not have Part A (B) coverage when you received this service. If you disagree, please contact us at the customer service number shown on this notice.

5.6 - The name or Medicare number was incorrect or missing. Ask your provider to use the name or number shown on this notice for future claims.

DRUGS

6.1 - This drug is covered only when Medicare pays for the transplant.

6.2 - Drugs not specifically classified as effective by the Food and Drug Administration are not covered.

6.3 - Payment cannot be made for oral drugs that do not have the same active ingredients as they would have if given by injection.

6.4 - Medicare does not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours after administration of a Medicare covered chemotherapy drug.

DUPLICATES

7.1 - This is a duplicate of a charge already submitted.

7.2 - This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.

DURABLE MEDICAL EQUIPMENT

8.1 - Your supplier is responsible for the servicing and repair of your rented equipment.

8.2 - To receive Medicare payment, you must have a doctor's prescription before you rent or purchase this equipment.

8.3 - This equipment is not covered because its primary use is not for medical purposes.

8.4 - Payment cannot be made for equipment that is the same or similar to equipment already being used.

8.5 - Rented equipment that is no longer needed or used is not covered.

8.6 - A partial payment has been made because the purchase allowance has been reached. No further rental payments can be made.

8.7 - This equipment is covered only if rented.

8.8 - This equipment is covered only if purchased.

8.9 - Payment has been reduced by the amount already paid for the rental of this equipment.

8.10 - Payment is included in the approved amount for other equipment.

8.11 - The purchase allowance has been reached. If you continue to rent this piece of equipment, the rental charges are your responsibility.

8.12 - The approved charge is based on the amount of oxygen prescribed by the doctor.

8.13 - Monthly rental payments can be made for up to 15 months from the first paid rental month or until the equipment is no longer needed, whichever comes first.

8.14 - Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month.

8.15 - Maintenance and/or servicing of this item is not covered until 6 months after the end of the 15th paid rental month.

8.16 - The approved amount includes payment for all covered stationary oxygen equipment, contents and accessory items for an entire rental month.

8.17 - Payment for this item is included in the monthly rental payment amount.

8.18 - Payment is denied because the supplier did not have a written order from your doctor prior to delivery of this item.

8.19 - Sales tax is included in the approved amount for this item.

8.20- Medicare does not pay for this equipment or item.

8.21 - This item cannot be paid without a new, revised or renewed certificate of medical necessity.

8.22 - No further payment can be made because the cost of repairs has equaled the purchase price of this item.

8.23 - No payment can be made because the item has reached the 15 month limit. Separate payments can be made for maintenance or servicing every 6 months.

8.24 - The claim does not show that you own or are purchasing the equipment requiring these parts or supplies.

8.25 - Payment cannot be made until you tell your supplier whether you want to rent or buy this equipment.

8.26 - Payment is reduced by 25% beginning the 4th month of rental.

8.27 - Payment is limited to 13 monthly rental payments because you have decided to purchase this equipment.

8.28 - Maintenance, servicing, replacement or repair of this item is not covered.

8.29 - Payment is allowed only for the seat lift mechanism, not the entire chair.

8.30 - This item is not covered because the doctor did not complete the certificate of medical necessity.

8.31 - Payment is denied because blood gas tests cannot be performed by a durable medical equipment supplier.

8.32 - This item can only be rented for two months. If the item is still needed, it must be purchased.

8.33 - This is the next to last payment for this item.

8.34 - This is the last payment for this item.

8.35 - This item is not covered when oxygen is not being used.

8.36 - Payment is denied because the certificate of medical necessity on file was not in effect for this date of service.

8.37 - An oxygen recertification form was sent to the physician.

8.38 - This item must be rented for 2 months prior to purchasing it.

8.39 - This is the 10th month of rental payment. Your supplier should offer you the choice of changing the rental to a purchase agreement.

8.40 - We have previously paid for the purchase of this item.

8.41 - Payment for the amount of oxygen supplied has been reduced or denied because the monthly limit has been reached.

8.42 - Standby equipment is not covered.

8.43 - Payment has been denied because this equipment cannot deliver the liters per minute prescribed by your doctor.

8.44 - Payment is based on a standard item because information did not support the need for a deluxe or more expensive item.

8.45 - Payment for electric wheelchairs is allowed only if the purchase decision is made in the first or tenth month of rental.

8.46 - Payment is included in the allowance for another item or service provided at the same time.

8.47 - Supplies or accessories used with noncovered equipment are not covered.

8.48 - Payment for this drug is denied because the need for the equipment has not been established.

8.49 - This allowance has been reduced because part of this item was paid on another claim.

8.50 - Medicare cannot pay for this drug/equipment because our records do not show your supplier is licensed to dispense prescription drugs, and, therefore, cannot assure the safety and effectiveness of the drug/equipment. You are not financially liable for any amount for this drug/equipment unless your supplier gave you a written notice in advance that Medicare would not pay for it and you agreed to pay.

FAILURE TO FURNISH INFORMATION

9.1 - The information we requested was not received.

9.2 - This item or service was denied because information required to make payment was missing.

9.3 - Please ask your provider to submit a new, complete claim to us. (NOTE: Add-on to other messages as appropriate)

9.4 - This item or service was denied because information required to make payment was incorrect.

9.5 - Our records show your doctor did not order this supply or amount of supplies.

9.6 - Please ask your provider to resubmit this claim with a breakdown of the charges or services.

9.7 - We have asked your provider to resubmit the claim with the missing or correct information. (NOTE: Add-on to other messages as appropriate)

9.8 - The hospital has been asked to submit additional information, you should not be billed at this time.

FOOT CARE

10.1 - Shoes are only covered as part of a leg brace.

TRANSFER OF CLAIMS OR PARTS OF CLAIMS

11.1 - Your claim has been forwarded to the correct Medicare contractor for processing. You will receive a notice from them. (NOTE: Use for Carriers, Intermediaries, RRB, United Mine Workers)

11.2 - This information is being sent to Medicaid. They will review it to see if additional benefits can be paid.

11.3 - Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them.

11.4 - Our records show that you are enrolled in a health maintenance organization. Your claim was sent to them for processing.

11.5 - This claim will need to be submitted to (another carrier, a durable medical equipment regional carrier (DMERC), Medicaid agency).

11.6 - We have asked your provider to resubmit this claim to the proper carrier (intermediary). That carrier (intermediary) is (name and address of carrier, intermediary or durable medical equipment regional carrier, etc.)

HEARING AIDS

12.1 - Hearing aids are not covered.

SKILLED NURSING FACILITY

13.1 - No qualifying hospital stay dates were shown for this Skilled Nursing Facility stay.

13.2 - Skilled Nursing Facility benefits are only available after a hospital stay of at least 3 days.

13.3 - Information provided does not support the need for skilled nursing facility care.

13.4 - Information provided does not support the need for continued care in a skilled nursing facility.

13.5 - You were not admitted to the skilled nursing facility within 30 days of your hospital discharge.

13.6 - Rural primary care skilled nursing facility benefits are only available after a hospital stay of at least 2 days. (NOTE: This message is used only in connection with hospital stays that occurred prior to October 1, 1997).

LABORATORY

14.1 - The laboratory is not approved for this type of test.

14.2 - Medicare approved less for this individual test because it can be done as part of a complete group of tests.

14.3 - Services or items not approved by the Food and Drug Administration are not covered.

14.4 - Payment denied because the claim did not show who performed the test and/or the amount charged.

14.5 - Payment denied because the claim did not show if the test was purchased by the physician or if the physician performed the test.

14.6 - This test must be billed by the laboratory that did the work.

14.7 - This service is paid at 100% of the Medicare approved amount. (NOTE: Mandated message This message must appear on all service lines paid at 100% of the Medicare approved amount.)

14.8 - Payment cannot be made because the physician has a financial relationship with the laboratory.

14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim.

14.10 - Medicare does not allow a separate payment for EKG readings.

14.11 - A travel allowance is paid only when a covered specimen collection fee is billed.

14.12 - Payment for transportation can only be made if an X-ray or EKG is performed.

14.13 - The laboratory was not approved for this test on the date it was performed.

MEDICAL NECESSITY

15.1 - The information provided does not support the need for this many services or items.

15.2 - The information provided does not support the need for this equipment.

15.3 - The information provided does not support the need for the special features of this equipment.

15.4 - The information provided does not support the need for this service or item.

15.5 - The information provided does not support the need for similar services by more than one doctor during the same time period.

15.6 - The information provided does not support the need for this many services or items within this period of time.

15.7 - The information provided does not support the need for more than one visit a day.

15.8 - The information provided does not support the level of service as shown on the claim.

15.9 - The Peer Review Organization did not approve this service.

15.10 - Medicare does not pay for more than one assistant surgeon for this procedure.

15.11 - Medicare does not pay for an assistant surgeon for this procedure/surgery.

15.12 - Medicare does not pay for two surgeons for this procedure.

15.13 - Medicare does not pay for team surgeons for this procedure.

15.14 - Medicare does not pay for acupuncture.

15.15- Payment has been reduced because information provided does not support the need for this item as billed.

15.16- Your claim was reviewed by our Medical Staff. (NOTE: Add-on to other messages as appropriate).

15.17- We have approved this service at a reduced level. (NOTE: Add-on to other messages as appropriate)

MISCELLANEOUS

16.1 - This service cannot be approved because the date on the claim shows it was billed before it was provided.

16.2 - This service cannot be paid when provided in this location/facility.

16.3 - The claim did not show that this service or item was prescribed by your doctor.

16.4 - This service requires prior approval by the Peer Review Organization.

16.5 - This service cannot be approved without a treatment plan by a physical or occupational therapist.

16.6 - This item or service cannot be paid unless the provider accepts assignment.

16.7 - Your provider must complete and submit your claim.

16.8 - Payment is included in another service received on the same day.

16.9 - This allowance has been reduced by the amount previously paid for a related procedure.

16.10 - Medicare does not pay for this item or service.

16.11- Payment was reduced for late filing. You cannot be billed for the reduction. (NOTE: Mandated message - This message must print on all service lines subject to the 10% reduction.)

16.12- Outpatient mental health services are paid at 50 percent of the approved charges. (NOTE: Mandated message - This message must print on all service lines subject to the outpatient psychiatric reduction when no deductible has been applied.)

16.13 - The code(s) your provider used is/are not valid for the date of service billed.

16.14 - The attached check replaces your previous check (#) dated .

16.15- The attached check replaces your previous check. (NOTE: Use only if prior check information is not accessible by the system.)

16.16- As requested, this is a duplicate copy of your Medicare Summary Notice.

16.17- Medicare does not pay for these services when they are not given in conjunction with total parenteral nutrition.

16.18- Service provided prior to the onset date of certified parenteral/enteral nutrition therapy is not covered.

16.19- The approved amount of this parenteral/enteral nutrition supply is based on a less extensive level of care for the nature of the diagnosis stated.

16.20- The approved payment for calories/grams is the most Medicare may allow for the diagnosis stated.

16.21 - The procedure code was changed to reflect the actual service rendered.

16.22 - Medicare does not pay for services when no charge is indicated.

16.23 - This check is for the excess amount you paid toward a prior overpayment.

16.24- Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, the service must be provided by a doctor licensed to practice in the United States.

16.25 - Medicare does not pay for this much equipment, or this many services or supplies.

16.26- Medicare does not pay for services or items related to a procedure that has not been approved or billed.

16.27 - This service is not covered since our records show you were in the hospital at this time.

16.28 - Medicare does not pay for services or equipment that you have not received.

16.29 - Payment is included in another service you have received.

16.30 - Services billed separately on this claim have been combined under this procedure.

16.31 - You are responsible to pay the primary physician the agreed monthly charge.

16.32 - Medicare does not pay separately for this service.

16.33- Your payment includes interest because Medicare exceeded processing time limits. (NOTE: Mandated message - This message must print claim level if interest is added into the beneficiary payment amount for unassigned or split pay claims.)

16.34- You should not be billed for this service. You do not have to pay this amount. (NOTE: Add-on to other messages, or use individually as appropriate.)

16.35- You do not have to pay this amount. (NOTE: Add-on to other messages as appropriate.)

16.36- If you have already paid it, you are entitled to a refund from this provider. (NOTE: Add-on to other messages as appropriate.)

16.37- Please see the back of this notice. (NOTE: Add-on to other messages as you feel appropriate.)

16.38- Charges are not incurred for leave of absence days.

16.39- Only one provider can be paid for this service per calendar month. Payment has already been made to another provider for this service.

16.40- Only one inpatient service per day is allowed.

16.41- Payment is being denied because you refused to request reimbursement under your Medicare benefits.

16.42 - The provider's determination of noncoverage is correct.

16.43 -This service cannot be approved without a treatment plan and supervision of a doctor.

16.44 -Routine care is not covered.

16.45- You cannot be billed separately for this item or service. You do not have to pay this amount.

16.46- Medicare payment limits do not affect a Native American"s right to free care at Indian Health Institutions.

16.47- When deductible is applied to outpatient psychiatric services, you may be billed for up to the approved amount. The "You May Be Billed" column will tell you the correct amount to pay your provider.

NON-PHYSICIAN SERVICES

17.1 - Services performed by a private duty nurse are not covered.

17.2 - This anesthesia service must be billed by a doctor.

17.3 - This service was denied because you did not receive it under the direct supervision of a doctor.

17.4 - Services performed by an audiologist are not covered except for diagnostic procedures.

17.5 - Your provider's employer must file this claim and agree to accept assignment.

17.6 - Full payment was not made for this services because the yearly limit has been met.

17.7 - This service must be performed by a licensed clinical social worker.

17.8 - Payment was denied because the maximum benefit allowance has been reached.

17.9 - Medicare (Part A / Part B) pays for this service. The provider must bill the correct Medicare contractor. (NOTE: Insert appropriate program. Message is used for Part A claims received by Part B or Part B claims received by Part A.)

17.10- The allowance has been reduced because the anesthesiologist medically directed concurrent procedures.

17.11- This item or service cannot be paid as billed.

17.12 -This service is not covered when provided by an independent therapist.

17.13- Medicare approves up to ($) a year for services billed by a physical or occupational therapist. (NOTE: Insert appropriate dollar amount.)

17.14- Charges for maintenance therapy are not covered.

17.15- This service cannot be paid unless certified by your physician every ( ) days. (NOTE: Insert appropriate number of days.)

17.16- The hospital should file a claim for Medicare benefits because these services were performed in a hospital setting.

PREVENTIVE CARE

18.1 - Routine examinations and related services are not covered.

18.2 - This immunization and/or preventive care is not covered.

18.3 - Screening mammography is not covered for women under 35 years of age.

18.4- This service is being denied because it has not been 12 months since your last examination of this kind. (NOTE: Insert appropriate number of months.)

18.5 - Medicare will pay for another screening mammogram in (12, 24) months. (NOTE: Insert appropriate number of months.)

18.6 - A screening mammography is covered only once for women age 35 - 39.

18.7 - Screening pap smears are covered only once every 36 months unless high risk factors are present.

18.8 - Screening mammograms are covered for women 40 - 49 years of age without high risk factors only once every 24 months.

18.9 - Screening mammograms are covered for women 40 - 49 years of age with high risk factors only once every 12 months.

18.10- Screening mammograms are covered for women 50 - 64 years of age once every 12 months.

18.11- Screening mammograms are covered for women 65 years of age and older only once every 24 months.

18.12- Screening mammograms are covered annually for woman 40 years of age and older.

18.13- This service is not covered for beneficiaries under 50 years of age.

18.14- Service is being denied because it has not been (12,24,48) months since your last (test/procedure) of this kind.

18.15- Medicare only covers this procedure for beneficiaries considered to be at high risk for colorectal cancer.

18.16- This service is being denied because payment has already been made for a similar procedure within a set timeframe.

18.17- Medicare pays for screening Pap smear and/or screening pelvic examination only once every 3 years unless high risk factors are present.

18.18- Medicare does not pay for this service separately since payment of it is included in our allowance for other services you received on the same day.

HOSPITAL BASED PHYSICIANS SERVICES

19.1 - Services of a hospital based specialist are not covered unless there is an agreement between the hospital and the specialist.

19.2 - Payment was reduced because this service was performed in a hospital outpatient setting rather than a provider's office.

19.3 - Only one hospital visit or consultation per provider is allowed per day.

BENEFIT LIMITS

20.1 - You have used all of your benefit days for this period.

20.2 - You have reached your limit of 190 days of psychiatric hospital services.

20.3 - You have reached your limit of 60 lifetime reserve days.

20.4 - ( ) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (NOTE: Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)

20.5 - These services cannot be paid because your benefits are exhausted at this time.

20.6 - Days used has been reduced by the primary group insurer's payment.

20.7 - You have day(s) remaining of your 190 day psychiatric limit.

20.8- Days used are being subtracted from your total (inpatient or skilled nursing facility) benefits for this benefit period.

20.9- Services after mm/dd/yy cannot be paid because your benefits were exhausted.

RESTRICTIONS TO COVERAGE

21.1 - Services performed by an immediate relative or a member of the same household are not covered.
21.2 - The provider of this service is not eligible to receive Medicare payments.

21.3 - This provider was not covered by Medicare when you received this service.

21.4 - Services provided outside the United States are not covered. See your Medicare Handbook for services received in Canada and Mexico.

21.5 - Services needed as a result of war are not covered.

21.6 - This item or service is not covered when performed, referred, or ordered by this provider.

21.7 - This service should be included on your inpatient bill.

21.8 - Services performed using equipment that has not been approved by the Food and Drug Administration are not covered.

21.9 - Payment cannot be made for unauthorized service outside the managed care plan.

21.10 -A surgical assistant is not covered for this place and/or date of service.

21.11 -This service was not covered by Medicare at the time you received it.

21.12- This hospital service was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.

21.13- This surgery was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.

21.14- Medicare cannot pay for this investigational device because the FDA clinical trial period as not begun.

21.15- Medicare cannot pay for this investigational device because the FDA clinical trial period has ended.

21.16- Medicare does not pay for this investigational device.

21.17- Your provider submitted noncovered charges for which you are responsible.

21.18- This item or service is not covered when performed or ordered by this provider.

21.19- This provider decided to drop out of Medicare. No payment can be made for this service, you are responsible for this charge. Under Federal law your doctor cannot charge you more than the limiting charge amount.

21.20- The provider decided to drop-out of Medicare. No payment can be made for this service, you are responsible for this charge.

SPLIT CLAIMS

22.1 - Your claim was separated for processing. The remaining services may appear on a separate notice.

SURGERY

23.1 - The cost of care before and after the surgery or procedure is included in the approved amount for that service.

23.2 - Cosmetic surgery and related services are not covered.

23.3 - Medicare does not pay for surgical supports except primary dressings for skin grafts.

23.4 - A separate charge is not allowed because this service is part of the major surgical procedure.

23.5 - Payment has been reduced because a different doctor took care of you before and/or after the surgery.

23.6 - This surgery was reduced because it was performed with another surgery on the same day.

23.7 - Payment cannot be made for an assistant surgeon in a teaching hospital unless a resident doctor was not available.

23.8 - This service is not payable because it is part of the total maternity care charge.

23.9 - Payment has been reduced because the charges billed did not include post-operative care.

23.10- Payment has been reduced because this procedure was terminated before anesthesia was started.

23.11- Payment cannot be made because the surgery was canceled or postponed.

23.12- Payment has been reduced because the surgery was canceled after you were prepared for surgery.

23.13- Because you were prepared for surgery and anesthesia was started, full payment is being made even though the surgery was canceled.

23.14- The assistant surgeon must file a separate claim for this service.

23.15- The approved amount is less because the payment is divided between two doctors. (NOTE: use for global reductions.)

23.16- An additional amount is not allowed for this service when it is performed on both the left and right sides of the body.

FRAUD AND ABUSE (HELP STOP FRAUD)

24.1 - Protect your Medicare number as you would a credit card number.

24.2 - Beware of telemarketers or advertisements offering free or discounted Medicare items and services.

24.3 - Beware of door-to-door solicitors offering free or discounted Medicare items or services.

24.4 - Only your physician can order medical equipment for you.

24.5 - Always review your Medicare Summary Notice for correct information about the items or services you received.

24.6 - Do not sell your Medicare number or Medicare Summary Notice.

24.7 - Do not accept free medical equipment you don't need.

24.8 - Beware of advertisements that read, "This item is approved by Medicare", or "No out-of-pocket expenses."

24.9 - Be informed - Read your Medicare Summary Notice.

24.10 -Always read the front and back of your Medicare Summary Notice.

24.11- Beware of Medicare scams, such as offers of free milk or cheese for your Medicare number.
24.12- Read your Medicare Summary Notice carefully for accuracy of dates, services, and amounts billed to Medicare.

24.13 -Be sure you understand anything you are asked to sign.

24.14 -Be sure any equipment or services you received were ordered by your doctor.

TIME LIMIT FOR FILING

25.1 - This claim was denied because it was filed after the time limit.

25.2 - You can be billed only 20 percent of the charges that would have been approved.

VISION

26.1 - Eye refractions are not covered.

26.2 - Eyeglasses or contact lenses are covered only after cataract surgery or if the natural lens of your eye is missing.

26.3 - Only one pair of eyeglasses or contact lenses is covered after cataract surgery with lens implant.

26.4 - This service is not covered when performed by this provider.

26.5 - This service is covered only in conjunction with cataract surgery.

26.6 - Payment was reduced because the service was terminated early.

HOSPICE

27.1 - This service is not covered because you are enrolled in a hospice.

27.2 - Medicare will not pay for inpatient respite care when it exceeds five (5) consecutive days at a time.

27.3 - The physician certification requesting hospice services was not received timely.

27.4 - The documentation received indicates that the general inpatient services were not related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate.

27.5 - Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate.

27.6 - The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the routine home care rate.

27.7 - According to Medicare hospice requirements, the hospice election consent was not signed timely.

27.8 - The documentation submitted does not support that your illness is terminal.

27.9 - The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.

27.10- The documentation indicates that the level of continuous care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.

27.11- The provider has billed in error for the routine home care items or services received.

MANDATORY ASSIGNMENT FOR PHYSICIAN SERVICES FURNISHED FOR MEDICAID PATIENTS

28.1 - Because you have Medicaid, your provider must agree to accept assignment.

MSP

29.1 - Secondary payment cannot be made because the primary insurer information was either missing or incomplete.

29.2 - No payment was made because your primary insurer's payment satisfied the provider's bill.

29.3 - Medicare benefits are reduced because some of these expenses have been paid by your primary insurer.

29.4 - In the future, if you send claims to Medicare for secondary payment, please send them to (carrier MSP address).

29.5 - Our records show that Medicare is your secondary payer. This claim must be sent to your primary insurer first. (NOTE: Use "Add-on" message as appropriate).

29.6 - Our records show that Medicare is your secondary payer. Services provided outside your prepaid health plan are not covered. We will pay this time only since you were not previously notified.

29.7- Medicare cannot pay for this service because it was furnished by a provider who is not a member of your employer prepaid health plan. Our records show that you were informed of this rule.

29.8 - This claim is denied because the service(s) may be covered by the worker"s compensation plan. Ask your provider to submit a claim to that plan.

29.9 - Since your primary insurance benefits have been exhausted, Medicare will be primary on this accident related service.

29.10- These services cannot be paid because you received them on or before you received a liability insurance payment for this injury or illness.

29.11- Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer. (NOTE: Use "Add-on" message as appropriate).

29.12- Our records show that these services may be covered under the Black Lung Program. Contact the Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828. (NOTE: Use "Add-on" message as appropriate).

29.13- Medicare does not pay for these services because they are payable by another government agency. Submit this claim to that agency. (NOTE: Use "Add-on" message as appropriate).

29.14- Medicare's secondary payment is ($). This is the difference between the primary insurer's approved amount of ($) and the primary insurer's paid amount of ($). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and the

primary insurer's approved amount is higher than Medicare's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)

29.15- Medicare's secondary payment is ($). This is the difference between Medicare's approved amount of ($) and the primary insurer's paid amount of ($). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and Medicare's approved amount is higher than the primary insurer's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)

29.16- Your primary insurer approved and paid ($) on this claim. Therefore, no secondary payment will be made by Medicare. (NOTE: Mandated message - This message should print claim or service level when the primary insurer's approved amount is higher than Medicare's approved amount and the primary payment is equal to the approved amount. Do not print on denied service lines.)

29.17- Your provider agreed to accept ($) as payment in full on this claim. Your primary insurer has already paid ($) so Medicare's payment is the difference between the two amounts. (NOTE: Mandated message - This message should print claim level when the provider is obligated to accept less than the Medicare approved amount.)

29.18- The amount listed in the "You May Be Billed" column assumes that your primary insurerpaid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be

Billed" column. (NOTE: Mandated message - This message should print on all assigned MSP service lines when Medicare secondary payment was made. Print message on assigned service lines for full recoveries. Do not print on denied service lines.)

29.19- The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount charged and the amount the primary insurer paid. (NOTE: Mandated message - This message should print on all unassigned MSP service lines when Medicare secondary payment was made. Print message on unassigned service lines for full recoveries. Do not print on denied service lines. Do not print when conditions in 29.20 or 29.22 are met.)

29.20- The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider agreed to accept and the amount the primary insurer paid. (NOTE: This message should print on all unassigned MSP service lines when the provider is obligated to accept less than the Medicare approved amount. Do not print on denied service lines.)

29.21- The amount listed in the "You May Be Billed" column assumes that your primary insurer made no payment for this service. If your primary insurer did make payment for this service, the amount you may be billed is the difference between the amount charged and the primary insurer's payment. (NOTE: Mandated message - This message should print on all Medicare disallowed services for which the beneficiary is liable and the service has been submitted on a claim indicating there has been a primary insurer payment made.)

29.22- The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider can legally charge and the amount the primary insurer paid. See Note ( ) for the legal charge limit. (NOTE: This message should print on all unassigned MSP service lines when a Medicare secondary payment is made and the provider has exceeded the limiting charge.)

29.23- No payment can be made because payment was already made by either workers' compensation or the Federal Black Lung Program.

29.24- No payment can be made because payment was already made by another government entity.

29.25 - Medicare paid all covered services not paid by other insurer.

29.26- The primary payer is . (NOTE: Add-on to messages as appropriate and/or as your system permits.)
29.27 -Your primary group's payment satisfied Medicare deductible and coinsurance.

29.28- Your responsibility on this claim has been reduced by the amount paid by your primary insurer.

29.29- Your provider is allowed to collect a total of ($) on this claim. Your primary insurer paid ($) and Medicare paid ($). You are responsible for the unpaid portion of ($).

29.30- ($) of the money approved by your primary insurer has been credited to your Medicare Part B (A) deductible. You do not have to pay this amount.

29.31- Resubmit this claim with the missing or correct information.

29.32- Medicare's secondary payment is ($). This is the difference between Medicare's limiting charge amount of ($) and the primary insurer's paid amount of ($).
Note: Please refer to the exhibits for examples of MSP messages.

REASONABLE CHARGE AND FEE SCHEDULE

30.1 - The approved amount is based on a special payment method.

30.2 - The facility fee allowance is greater than the billed amount.

30.3 - Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($). If you have already paid more than this amount, you are entitled to a refund from the provider. (NOTE: This message should print on all unassigned service lines for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount the limiting charge is exceeded is less than any threshold established by HCFA.)

30.4 - A change in payment methods has resulted in a reduced or zero payment for this procedure.

ADJUSTMENTS

Note: You must print at least one of the messages in this section for all adjusted claims shown on the MSN.

31.1 - This is a correction to a previously processed claim and/or deductible record.

31.2 - A payment adjustment was made based on a telephone review.

31.3 - This notice is being sent to you as the result of a reopening request.

31.4 - This notice is being sent to you as the result of a fair hearing request.

31.5 - If you do not agree with the Medicare approved amount(s) and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the limit you may combine amounts on other claims that have been reviewed. At the hearing, you may present any new evidence which could affect the decision. Call us at the number in the Customer Service block if you need more information about the hearing process.

31.6 - A payment adjustment was made based on a Peer Review Organization request.

31.7 - This claim was previously processed under an incorrect Medicare claim number or name. Our records have been corrected.

31.8 - This claim was adjusted to reflect the correct provider.

31.9 - This claim was adjusted because there was an error in billing.

31.10- This is an adjustment to a previously processed charge (s). This notice may not reflect the charges as they were originally submitted.

31.11- The previous notice we sent stated that your doctor could not charge more than ($). This additional payment allows your doctor to bill you the full amount charged. (NOTE: Mandated message - This message should print service level, as appropriate, when limiting charge applies.)

31.12- The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($).

(NOTE: Mandated message - This message should print service level, as appropriate, when limiting charge applies.)

31.13- The Medicare paid amount has been reduced by ($) previously paid for this claim. (NOTE: Mandated message - This message should print claim level on all adjustments for which a partial payment was previously made.)

31.14 -This payment is the result of an Administrative Law Judge's decision.

31.15 An adjustment was made based on a review decision.

31.16 An adjustment was made based on a reconsideration.

OVERPAYMENTS/OFFSETS

32.1 - ($) dollars of this payment has been withheld to recover a previous overpayment. (NOTE: Mandated message - This message should print claim level when the beneficiary check amount is reduced to recover a previous overpayment. Fill in the blank with the amount withheld on the claim at issue.)

AMBULATORY SURGICAL CARE

33.1 - The ambulatory surgical center must bill for this service.

PATIENT PAID / SPLIT PAYMENTS

34.1 - Of the total ($) paid on this claim, we are paying you ($) because you paid your provider more than your 20 percent co-insurance on Medicare approved services. The remaining ($) was paid to the provider. (NOTE: Mandated message - This message should print claim level on all assigned claims generating payment to the beneficiary.)

34.2 - The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered. (NOTE: Mandated message - This message should print claim level on all assigned claims with a beneficiary paid amount that does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.)

34.3 - After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00) (NOTE: Use this message only when your system cannot plug the dollar amount in message 34.8)

34.4 - We are paying you ($) because the amount you paid the provider was more than you may be billed for Medicare approved charges.

34.5 - The amount owed you is ($). Medicare does not routinely issue checks for amounts under $1.00. This amount due will be included in your next check. If you want this money issued immediately, please contact us at the address or phone number in the Customer Service Information Box.

34.6 - Your check includes ____ which was withheld on a prior claim.

34.7 - This check includes an amount less than $1.00 which was withheld on a prior claim. (NOTE: Use this message only when your system cannot plug the dollar amount in message 34.6.)

34.8 - The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of $.XX from your provider, which is the difference between what you paid and what you should have paid. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00)

SUPPLEMENTAL COVERAGE / MEDIGAP

35.1 - This information is being sent to your private insurer(s). Send any questions regarding your benefits to them. (NOTE: Add if possible : Your private insurer(s) is/are .)

35.2 - We have sent your claim to your Medigap insurer. Send any questions regarding your benefits to them. (NOTE: Add if possible: Your Medigap insurer is .)

35.3 - A copy of this notice will not be forwarded to your Medigap insurer because the information was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.

35.4 - A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.

35.5 - We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them.

35.6 - Your supplemental policy is not a Medigap policy under Federal and State law/regulation. It is your responsibility to file a claim directly with your insurer.

35.7 - Please do not submit this notice to them. (NOTE: Add-on to other messages as appropriate)

LIMITATION OF LIABILITY

36.1 - Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.

36.2 - It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: 1) a copy of this notice, 2) your provider's bill and, 3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.

36.3 - Your provider has been notified that you are due a refund if you paid for this service. If you do not receive a refund from the provider within 30 days from your receipt of this notice, please write our office and include a copy of this notice. Your provider has the right to appeal this decision, which may change your right to a refund.

36.4 - This payment refunds the full amount you paid to your provider for the services previously processed and denied. You are entitled to this refund because your provider did not tell you in writing before providing the service(s) that Medicare would not pay for the denied service (s). In the future, you will have to pay for this service when it is denied.

36.5 - This payment refunds the full amount you are entitled to for services previously processed and reduced. You are entitled to this refund because your provider did not tell you in writing before providing the service (s) that Medicare would approve it at a lower amount. In the future, you will have to pay for the service as billed when it is reduced.

36.6 - Medicare is paying this claim, this time only, because it appears that neither you nor the provider knew that the service(s) would be denied. Future services of this type provided to you will be your responsibility.

DEDUCTIBLE / COINSURANCE

Print the following messages in the Notes Section as appropriate.

37.1 - This approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with the total approved amount applied to the deductible.)

37.2 - ($) of this approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with a portion of the approved amount applied to the deductible.)

37.3 - ( ) was applied to your inpatient deductible. (NOTE: Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.)

37.4 - ( ) was applied to your inpatient coinsurance.

37.5 - ( ) was applied to your skilled nursing facility coinsurance.

37.6 - ( ) was applied to your blood deductible.

37.7 - Part B cash deductible does not apply to these services.

37.8 - Coinsurance amount includes outpatient mental health treatment limitation.
Print the following messages in the "Deductible Information Section" as appropriate. Print a message for each different type of deductible situation displayed on the MSN. Do not print more than one type of deductible message for each year represented on the MSN. (For Example, Do not print both 37.9 and 37.11 on the same MSN.)

37.9 - You have now met ($) of your ($) Part B deductible for (year).

37.10- You have now met ($) of your ($) Part A deductible for this benefit period.

37.11- You have met the Part B deductible for (year).

37.12- You have met the Part A deductible for this benefit period.

37.13- You have met the blood deductible for (year).

37.14- You have met ( ) pint(s) of your blood deductible for (year).

GENERAL INFORMATION

38.1 - If you think Medicare was billed for something you did not receive, please call our Fraud Hotline, (phone number of Fraud Hotline).

38.2 - If you were offered free items or services but Medicare was billed, please call our Fraud Hotline, (phone number of Fraud Hotline)

38.3 - If you change your address, please contact (contractor's name) by calling (contractor's phone) and the Social Security Administration by calling 1-800-772-1213.

SECTION 39-"ADD-ON" MESSAGES

9.3 - Please ask your provider to submit a new complete claim to us. (NOTE: Add-on to other messages as appropriate.)

9.7 - We have asked your provider to resubmit the claim with the missing or correct information. (NOTE: Add-on to other messages as appropriate.)

15.16- Your claim was reviewed by our Medicare staff. (NOTE: Add-on to other messages as appropriate.)

15.17- We have approved this service at a reduced level. (NOTE: Add-on to other messages as appropriate.)

16.34- You should not be billed for this item or service. You do not have to pay this amount. (NOTE: Add-on to other messages, or use individually as appropriate.)

16.35- You do not have to pay this amount. (NOTE: Add-on to other messages as appropriate.)

16.36- If you have already paid it, you are entitled to a refund from this provider. (NOTE: Add-on to other messages as appropriate.)

16.37- Please see the back of this notice. (NOTE: Add-on to other messages as you feel appropriate.)

16.45 -You cannot be billed separately for this item or service. You do not have to pay this amount.

25.2 - You can be billed only 20 percent of the charges that would have been approved. (NOTE: Add-on to 25.1 for assigned claims.)

29.26 -The primary payer is . (NOTE: Add-on to other messages as appropriate.)

29.31 Resubmit this claim with the missing or correct information.

35.7 - Please do not submit this notice to them. (NOTE: Add-on to other messages as appropriate)

SECTION 40-MANDATED MESSAGES

14.7 - This service is paid at 100% of the Medicare approved amount. (NOTE: Mandated message -This message must appear on all service lines paid at 100% of the Medicare approved amount.)

16.11- Payment was reduced for late filing. You cannot be billed for the reduction. (NOTE: Mandated message - This message must print on all service lines subject to the 10% reduction.)

16.12- Outpatient mental health services are paid at 50 percent of the approved charges. (NOTE: Mandated message - This message must print on all service lines subject to the outpatient psychiatric reduction.)

16.33- Your payment includes interest because Medicare exceeded processing time limits. (NOTE: Mandated message - This message must print claim level if interest is added into the beneficiary payment amount for unassigned or split pay claims.)

20.4 - ( ) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (NOTE: Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)

29.14- Medicare's secondary payment is ($). This is the difference between the primary insurer's approved amount of ($) and the primary insurer's paid amount of ($). (NOTE: Mandated message

- This message should print claim level when a Medicare secondary payment is made and the primary insurer's approved amount is higher than Medicare's approved amount. Do not print when the claim paid amount is the amount Medicare would pay if services were not covered by a third party insurer.)

29.15- Medicare's secondary payment is ($). This is the difference between Medicare's approved amount of ($) and the primary insurer's paid amount of ($). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and Medicare's approved amount is higher than the primary insurer's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)

29.16- Your primary insurer approved and paid ($) on this claim. Therefore, no secondary payment will be made by Medicare. (NOTE: Mandated message - This message should print claim or service level when the primary insurer's approved amount is higher than Medicare's approved amount and the primary payment is equal to the approved amount. Do not print on denied service lines.)

29.17- Your provider agreed to accept ($) as payment in full on this claim. Your primary insurer has already paid ($) so Medicare's payment is the difference between the two amounts. (NOTE: Mandated message - This message should print claim level when the provider is obligated to accept less than the Medicare approved amount.)

29.18- The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed" column. (NOTE: Mandated message - This message should print on all assigned MSP service lines when Medicare secondary payment was made. Print message on assigned service lines for full recoveries. Do not print on denied service lines.)

29.19- The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount charged and the amount the primary insurer paid. (NOTE: Mandated message - This message should print on all unassigned MSP service lines when Medicare secondary payment was made. Print message on unassigned service lines for full recoveries. Do not print on denied service lines. Do not print when conditions in 29.20 or 29.22 are met.)

29.20- The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider agreed to accept and the amount the primary insurer paid. (NOTE: This message should print on all unassigned MSP service lines when the provider is obligated to accept less than the Medicare approved amount. Do not print on denied service lines.)

29.21- The amount listed in the "You May Be Billed" column assumes that your primary insurer made no payment for this service. If your primary insurer did make payment for this service, the amount you may be billed is the difference between the amount charged and the primary insurer's payment. (NOTE: Mandated message - This message should print on all Medicare disallowed services for which the beneficiary is liable and the service has been submitted on a claim indicating there has been a primary insurer payment made.)

29.22- The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider can legally charge and the amount the primary insurer paid. See note ( ) for the legal charge limit. (NOTE: This message should print on all unassigned MSP service lines when a Medicare secondary payment is made and the provider has exceeded the limiting charge.)

30.3 - Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($). If you have already paid more than this amount, you are entitled to a refund from the provider. (NOTE: This message should print on all assigned

service lines for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount the limiting charge is exceeded is less than any threshold established by HCFA.)

34.3 - After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund Please contact your provider. (NOTE: Mandated message: This message should print on assigned claims with a split payment to the beneficiary under $1.00)

31.11- The previous notice we sent stated that your doctor could not charge more than ($). This additional payment allows your doctor to bill you the full amount charged. (NOTE: Mandated message - This message should print claim level, as appropriate, when limiting charge applies.)

31.12- The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($). (NOTE: Mandated message - This message should print claim level, as appropriate, when limiting charge applies.)

31.13- The Medicare paid amount has been reduced by ($) previously paid for this claim. (NOTE: Mandated message - This messages should printed claim level on all adjustments for which a partial payment was previously made.)

32.1 - ($) dollars of this payment has been withheld to recover a previous overpayment. (NOTE: Mandated message - This message should print claim level when the beneficiary check amount is reduced to recover a previous overpayment. Fill in the blank with the amount withheld on the claim at issue.)

34.1 - Of the total ($) paid on this claim, we are paying you ($) because you paid your provider more than your 20 percent coinsurance on Medicare approved services. The remaining ($) was paid to the provider. (NOTE: Mandated message - This message should print claim level on all assigned split pay claims.)

34.2 - The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered. (NOTE: Mandated message - This message should print claim level on all assigned claims with a beneficiary paid amount that does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.)

34.3 - After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00)

34.8 - The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of $.XX from your provider, which is the difference between what you paid and what you should have paid. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00)

37.1 - This approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with the total approved amount applied to the deductible.)

37.2 - ($) of this approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with a portion of the approved amount applied to the deductible.)

37.3 - ( ) was applied to your inpatient deductible. (NOTE: Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.)

Print the following messages in the "Deductible Information Section" as appropriate. Print all messages that apply. There must be at least one message printed in the Deductible Section for all MSNs.

37.9 - You have now met ($) of your ($) Part B deductible for (year).

37.10 -You have now met ($) of your ($) Part A deductible for this benefit period.

37.11 -You have met the Part B deductible for (year).

37.12 -You have met the Part A deductible for this benefit period.

37.13 -You have met the blood deductible for (year).

37.14 -You have met ( ) pints of your blood deductible.

HOME HEALTH

41.1 - Medicare will pay for this service only when it is provided in addition to other services.

41.2 - This service must be performed by a nurse with the required psychiatric nurse credentials.

41.3 - The medical information did not support the need for continued services.

41.4 - This item is not considered by Medicare to be appropriate for home use.

41.5 - Medicare does not pay for comfort or convenience items.

41.6 - This item was not furnished under a plan of care established by your physician.

41.7 - This item is not considered by Medicare to be a prosthetic and/or orthotic device.

41.8 - Based on the information provided, your illness or injury did not prevent you from leaving your home unaided.

41.9 - Services exceeded those ordered by your physician.

41.10- Patients eligible to receive home health benefits from another government agency are not eligible to receive Medicare benefits for the same service.

41.11- Doctors orders were incomplete.

41.12- The Provider has billed in error for items/services according to the medical record.

41.13 The Provider has billed for services/items not documented in your record.

41.14 This service/item was billed incorrectly.

41.15 The information shows that you can do your own personal care.

41.16 To receive Medicare payment, you must have a signed doctor's order before you receive the services.

DEMONSTRATION PROJECTS

60.1 - In partnership with physicians in your area, is participating in a Medicare demonstration project that uses a simplified payment method to combine all hospital and physician care related to your hospital service.

60.2 - The total Medicare approved amount for your hospital service is . Is the Part A Medicare amount for hospital services and is the Part B Medicare amount for physician services (of which Medicare pays 80%). You are responsible for any deductible and coinsurance amounts represented.

60.3 Medicare has paid _______ for hospital and physician services. Your Part A deductible is _________. Your Part A coinsurance is __________. Your Part B coinsurance is ________.

60.4 This claim is being processed under a demonstration project.

Spanish Messages

NOTE: These messages correspond numerically to the English messages.

AMBULANCIA

1.1 - El pago por la transportación está aprobado sólo hasta la facilidad más cercana que pueda proveer el cuidado necesario.

1.2 - El pago fue denegado porque la compañía de ambulancia no tiene la aprobación de Medicare.

1.3 - Servicio de ambulancia a una funeraria no está cubierto.

1.4 - Transportación en un vehículo que no sea una ambulancia no está cubierto por Medicare.

1.5 - Transportación a una facilidad para estar cerca de su hogar o de un familiar no está cubierto.

1.6 - Este servicio está incluido en el pago total por la transportación en ambulancia.

1.7 - Servicios de ambulancia a la oficina o desde la oficina del médico no están cubiertos.

1.8 - Este servicio fue denegado porque usted rehusó ser transportado(a).

1.9 - Pagos por servicios de ambulancia no incluyen millaje cuando usted no estaba en la ambulancia.

1.10 - Servicio de ambulancia aérea no está cubierto, porque usted no fue transportado(a) al aereopuerto en ambulancia.

1.11- La información suministrada no justifica la necesidad de una ambulancia aérea. La cantidad aprobada es basada en ambulancia terrestre.

SANGRE

2.1 - Las primeras tres pintas de sangre usadas cada año no son cubiertas por Medicare.

2.2 - Los cargos por sangre reemplazada no son cubiertos por Medicare.

QUIROPRÁCTICO

3.1 - Estos servicios son cubiertos solamente cuando radiografías recientes justifícan la necesidad del servicio.

DEFICIENCIA RENAL TERMINAL

4.1 - Este cargo representa más de la cantidad que Medicare paga por terapia de mantenimiento de una enfermedad renal.

4.2 - Este servicio es cubierto hasta (intercale número apropiado) meses después del transplante y estadía en el hospital.

4.3 - Recetas para drogas immunosupresivas son limitadas a una provisión para 30 días.

4.4 - Solamente un suplidor por mes puede ser pagado por estos suministros o servicios.

4.5 - Medicare paga al hospital por la parte profesional de este cargo.

4.6 - Este servicio fue reducido por el número de días que usted no estaba en el lugar de tratamiento acostumbrado.

4.7 - Pago por todo equipo y provisiones se hace a través de su centro de diálisis. Ellos envían la cuenta a Medicare por estos servicios.

4.8 - Este servicio no se pagó debido a que usted no eligió una opción para su equipo y suministros de diálisis.

4.9 - Este cargo se redujo o se denegó porque el pago máximo mensual permitido para este equipo de diálisis para el hogar y provisiones fue alcanzado.

4.10 - No más de ($_____) puede ser pagado mensualmente por estos suministros.

4.11 - La cantidad que aparece en la columna "Podría Ser Facturado" está basada en la cantidad aprobada por Medicare. Usted no es responsable por la diferencia entre la cantidad facturada y la cantidad aprobada.

NÚMERO/NOMBRE/INSCRIPCIÓN

5.1 - Nuestros archivos indican que usted no está cubierto(a) bajo el número de Medicare en esta notificación. Si usted no está de acuerdo, comuníquese con la oficina del Seguro Social.

5.2 - El nombre o número de Medicare es incorrecto o fue omitido. Por favor, revise su tarjeta de Medicare. Si la información en esta notificación es diferente a la de su tarjeta, comuníquese con el proveedor del servicio.

5.3 - Nuestros archivos indican que la fecha de fallecimiento fue antes de la fecha del servicio.

5.4 - Si usted cambia el cheque adjunto, usted está legalmente obligado a pagar por estos servicios. Si usted no desea asumir esta obligación, favor de devolvernos este cheque.

5.5 - Nuestros archivos indican que usted no tenía la Parte A cuando recibió éstos servicios. Si usted no está de acuerdo favor de llamar al número de Servicios al Cliente indicado en esta notificación.

5.6 - El nombre o número de Medicare es incorrecto o fue omitido. Pídale a su proveedor de servicios que use el nombre y número indicados en esta notificación para futuras reclamaciones.

DROGAS

6.1 - Este medicamento es cubierto solamente cuando Medicare paga por el transplante.

6.2 - Medicamentos que no están específicamente clasificados como efectivos por la Administración de Alimentos y Drogas no son cubiertos.

6.3 - No se puede pagar por medicamentos orales que no tengan los mismos ingredientes activos como tienen aquellos que sean administrados por inyección.

DUPLICADOS

7.1 - Este es un duplicado de un cargo previamente sometido.
7.2 - Este es un duplicado de una reclamación procesada por otro contratísta de Medicare. Usted debe recibir un Resumen de Medicare de ellos.

EQUIPO MÉDICO DURADERO

8.1 - Su suplidor es responsable por el servicio y reparación de su equipo alquilado.

8.2 - Para usted poder recibir un pago de Medicare, debió obtener una receta médica antes de alquilar o comprar este equipo.

8.3 - Este equipo no está cubierto ya que su uso primario no es por razones médicas.

8.4 - Medicare no paga por equipo que es igual o similar al equipo que usted está usando actualmente.

8.5 - Equipo alquilado que no es necesario ni usado, no está cubierto.

8.6 - Hemos hecho un pago parcial porque la cantidad permitida de compra ha sido alcanzada. No se pagarán gastos de alquiler adicionales.

8.7 - Este equipo está cubierto solamente cuando es alquilado.

8.8 - Este equipo está cubierto solamente cuando es comprado.

8.9 - El pago se redujo por la cantidad ya pagada por el alquiler de este equipo.

8.10 - El pago está incluido en la cantidad aprobada por otro equipo.

8.11- La cantidad de compra ha sido alcanzada. Si usted continúa alquilando esta pieza de equipo, los cargos por alquiler son su responsabilidad.

8.12- La cantidad aprobada está basada en la cantidad de oxígeno recetada por el médico.

8.13- Pagos mensuales por alquiler pueden hacerse hasta 15 meses desde el primer mes de alquiler o hasta que el equipo no sea necesario, lo que ocurra primero.

8.14- Su suplidor debe proveer y dar servicio al equipo por el tiempo que sea necesario. Medicare pagará por el mantenimiento y/o servicio por cada periodo de 6 meses después de finalizar el pago 15 del alquiler.

8.15- Mantenimiento y/o servicio de este artículo no está cubierto hasta 6 meses después de finalizar el pago 15 de alquiler.

8.16- La cantidad aprobada incluye pago por todo el equipo de oxígeno, contenido y artículos accesorios por un mes completo de alquiler.

8.17- El pago por este artículo está incluido en la cantidad del pago mensual de alquiler.

8.18- Este pago se denegó porque el suplidor no obtuvo la orden por escrito del médico antes de entregar el artículo.

8.19- Los impuestos de venta fueron incluidos en la cantidad aprobada por este artículo.

8.20- Medicare no paga por este equipo o artículo.

8.21- Este artículo no puede ser pagado sin obtener un certificado de necesidad médica nuevo, revisado o renovado.

8.22- No se pueden hacer más pagos porque el costo de las reparaciones ha igualado el precio de compra de este artículo.

8.23- No se puede hacer el pago debido a que el artículo ha llegado al límite de 15 meses. Pagos separados se pueden hacer por mantenimiento y reparaciones cada 6 meses.

8.24- La reclamación no demuestra que usted es dueño o esté comprando equipo que necesite estas piezas o suministros.

8.25- El pago no se hará hasta que usted le diga al suplidor si usted desea alquilar o comprar el equipo.

8.26- Empezando el cuarto mes de alquiler los pagos se reducen en 25%.

8.27- Los pagos de alquiler se limitan a 13 pagos porque usted decidió comprar el equipo.

8.28- El mantenimiento, servicio, reemplazo o reparación de este artículo no está cubierto.

8.29- El pago se autoriza para el mecanismo que levanta la silla, no para la silla completa.

8.30- Este artículo no está cubierto debido que el médico no llenó el certificado de necesidad médica.

8.31- El pago fue denegado porque exámenes de gas en la sangre no pueden ser administrados por un suplidor de equipo médico duradero.

8.32- Este artículo se puede alquilar por 2 meses solamente. Debe ser comprado si lo necesita por más tiempo.

8.33- Este es el penúltimo pago por este artículo.

8.34- Este es el último pago por este artículo.

8.35- Este artículo no está cubierto cuando el oxígeno no está en uso.

8.36- El pago se denegó debido a que el certificado de necesidad médica en nuestros archivos no estaba en efecto en la fecha de este servicio.

8.37- Un formulario de re-certificación fue enviado a su médico.

8.38- Este artículo debe ser alquilado por 2 meses antes de comprarlo.

8.39- Este es el décimo mes de pago por alquiler. Su suplidor le debe ofrecer la opción de cambiar el acuerdo de alquiler a un acuerdo de compra.

8.40- Hemos pagado anteriormente por la compra de este artículo.

8.41- El pago por la cantidad de oxígeno suplido ha sido reducido o denegado debido a que el límite mensual ha sido alcanzado.

8.42- Equipo listo para usar en caso de necesidad no está cubierto.

8.43- El pago fue denegado debido que el equipo no puede proveer los litros por minuto recetados por su médico.

8.44- El pago fue basado en un artículo corriente debido que la información recibida no demostró la necesidad para usar uno de lujo o más costoso.

8.45- Los pagos para las sillas de ruedas eléctricas son permitidos si la decisión de compra fue hecha en el primer o décimo mes de alquiler.

8.46- El pago fue incluido en otro artículo o servicio proporcionado al mismo tiempo.

8.47- Medicare no pagará por suministros o accesorios usados con equipo que no está cubierto.

8.48- El pago de este medicamento ha sido denegado porque la necesidad de este equipo no ha sido demostrada.

8.49- El pago ha sido reducido porque parte de este artículo fue pagado en otra reclamación.

8.50- Medicare no puede pagar por esta medicina o por el equipo porque nuestros archivos indican que su suplidor no estaba autorizado a distribuir medicinas y por lo tanto no puede asegurar la efectividad ni la seguridad de la medicina o la del equipo. Usted no es responsable economicamente por ninguna cantidad para pagar por esta medicina o por el equipo a menos de que su suplidor le diera una notificación por escrito por adelantado de que Medicare no pagaría por éstos y usted estuvo de acuerdo en pagar.

FALTA DE INFORMACIÓN SOMETIDA

9.1- La información solicitada no fue recibida.

9.2- Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida.

9.3- Por favor solicite a su proveedor que nos envíe una nueva reclamación completa.

9.4- Este servicio fue denegado debido a que la información requerida para hacer el pago fue incorrecta.

9.5 - Nuestros archivos indican que su médico no ordenó estos suministros o cantidad de suministros.

9.6 - Favor de pedirle a su proveedor que someta esta reclamación con la lista detallada de los cargos o servicios.

9.7 - Le hemos pedido a su proveedor que envíe la reclamación con la información omitida o incorrecta.

9.8 - Le hemos pedido al hospital que nos provea información adicional, por ahora, usted no deberá recibir una factura.

CUIDADO DE LOS PIES

10.1 - Zapatos están cubiertos solamente como parte de una abrazadera de pierna.

RECLAMACIONES TRANSFERIDAS

11.1 - Su reclamación fue enviada al contratísta de Medicare apropiado para ser procesada. Usted recibirá una notificación de ellos. (NOTA: Usar para contratístas, Intermediarios, RRB, Unión de Trabajadores Mineros.)

11.2 - Esta información se está enviando a Medicaid. Ellos la revisarán para ver si beneficios adicionales pueden ser pagados.

11.3 - Nuestros archivos indican que usted está inscrito en una Organización para el Mantenimiento de la Salud. Su proveedor debe facturarle este servicio a ellos.

11.4 - Nuestros archivos indican que usted está registrado en una Organización para el Mantenimiento de la Salud. Su reclamación fue transferida a ellos para ser procesada.

11.5 - Esta reclamación debe ser sometida a Carolina Del Sur Blue Shield, TENS Unit, P.O. Box 102401, Columbia South Carolina, 29224 (Teléfona 1-800-868-2522), si la compañía suplidora está localizada al este del rio Mississippi. Esta reclamación debe ser sometida a Transamerica Occidental Life Insurance Company, Medicare, 1149 South Broadway, Los Angeles, California 90015, si la compañía suplidora está localizada al oeste del rio Mississippi.

11.6 - Le hemos pedido a su proveedor que resometa esta reclamación al intermediario apropiado. Dicho intermediario es Plametto Government Benefits Administrators, 300 Arbor Lake Drive, Suite 1300, Columbia SC 29223.

AUDIFONOS

12.1 - Audífonos no son cubiertos.

INSTALACION DE ENFERMERIA ESPECIALIZADA

13.1 - No se demostraron fechas aprobadas de estadía en el hospital para una estadía en esta instalación de enfermería especializada.

13.2 - Los beneficios de una instalación de enfermería especializada son obtenibles solamente después de una estadía en el hospital de por lo menos 3 días.

13.3 - La información proporcionada no confirma la necesidad de una estadía en una instalación de enfermería especializada.

13.4 - La información proporcionada no confirma la necesidad de continuar los servicios de cuidado de una instalación de enfermería especializada.

13.5 - Usted no fue ingresado en una instalación de enfermería especializada dentro de los 30 días después de ser dado de alta en el hospital.

13.6 - Los beneficios de cuidado primario en una instalación de enfermería especializada rural son obtenibles después de una estadía de hospital de por lo menos 2 días.

LABORATORIOS

14.1 - El laboratorio no está aprobado para este tipo de pruebas.

14.2 - Medicare aprobó _______ por ___________________________ específico porque puede ser hecho como parte de un grupo completo de pruebas.

14.3 - Servicios o artículos que no son aprobados por la Administración de Drogas y Alimentos no están cubiertos.

14.4 - El pago fue denegado debido a que la reclamación no indicaba quién realizó las pruebas y/o la cantidad cobrada.

14.5 - El pago fue denegado debido a que la reclamación no indicaba si las pruebas fueron compradas por el médico o si el médico realizó las pruebas.

14.6 - Estas pruebas deben ser facturadas por el laboratorio que hizo el trabajo.

14.7 - Este servicio es pagado al 100% de la cantidad aprobada por Medicare.

14.8 - No se puede pagar debido a que el médico tiene relaciones financieras con el laboratorio.

14.9 - Medicare no puede pagar por este servicio debido al diagnóstico indicado en la reclamación.

14.10 -Medicare no permite un pago por separado para la lectura del electro-cardiograma.

14.11- Gastos de viaje se pagan solamente cuando se factura por la colección de una muestra cubierta.
14.12- Medicare no paga por transportación si una radiografía o un electro-cardiograma no fue realizado.

14.13- El laboratorio no tenía la aprobación para esta prueba en la fecha que fue realizada.

NECESIDAD MEDICA

15.1 - La información proporcionada no confirma la necesidad de esta cantidad de servicios o artículos.

15.2 - La información proporcionada no confirma la necesidad para este equipo.

15.3 - La información proporcionada no confirma la necesidad para las características especiales de este equipo.

15.4 - La información proporcionada no confirma la necesidad para este servicio o artículo.

15.5 - La información proporcionada no confirma la necesidad por servicios similares por más de un médico durante el mismo periodo.

15.6 - La información proporcionada no confirma la necesidad de estos servicios o artículos en este periodo de tiempo.

15.7 - La información proporcionada no confirma la necesidad de más de una visita al día.

15.8 - La información proporcionada no confirma el nível de servicios según indicado en la reclamación.

15.9 - La Organización para la Revisión de Normas Profesionales no aprobó este servicio.

15.10- Medicare no paga por más de un asistente de cirujano para este procedimiento.

15.11- Medicare no paga por el asistente del cirujano por este procedimiento/cirugía.

15.12- Medicare no paga por dos cirujanos para este procedimiento.

15.13- Medicare no paga por un equipo de cirujanos para este procedimiento.

15.14- Medicare no paga por acupuntura.

15.15- El pago se redujo debido a que la información recibida no confirma la necesidad para este artículo como fue facturado.

15.16- Su reclamación fue revisada por nuestro personal médico.

15.17- Hemos aprobado este servicio con un índice de pago reducido.

MISCELANEO

16.1 - Este servicio no puede ser aprobado debido que la fecha en la reclamación indica que fue facturado antes del servicio.

16.2 - Este servicio no se puede pagar cuando es suministrado en esta sitio/facilidad.

16.3 - La reclamación no muestra que el servicio o artículo fue recetado por su médico.

16.4 - Este servicio requiere aprobación de la Organización de Revisión de Normas Profesionales.

16.5 - Este servicio no se aprobará sin el plan de tratamiento por el terapísta ocupacional o físico.

16.6 - Este artículo o servicio no se pagará a menos de que el proveedor acepte asignación.

16.7 - Su proveedor debe completar y someter su reclamación.

16.8 - El pago fue incluido en otro servicio recibido el mismo día.

16.9 - Este pago ha sido reducido por la cantidad previamente pagado por un procedimiento relacionado.

16.10- Medicare no paga por este artículo o servicio.

16.11- El pago fue reducido por enviar la reclamación tarde. A usted no le pueden cobrar esta reducción.

16.12- Servicios de salud mental como paciente externo se pagan al 50% del costo aprobado.

16.13- El/los código(s) que usó su proveedor no es/son válido(s) en la fecha de servicio facturada.

16.14- El cheque adjunto reemplaza su cheque _________ #_______, fechado ________.

16.15- El cheque adjunto reemplaza su cheque anterior.

16.16- De acuerdo a su solicitud, éste es un duplicado del Resumen de Medicare.

16.17- Medicare no paga por este servicio cuando no es proporcionado conjuntamente con una alimentación parenteral total.

16.18- Servicio proporcionado antes de la fecha autorizada para comenzar una terapia de alimentación parenteral/nasogástrica no está cubierto.

16.19- La cantidad aprobada para esta alimentación parenteral/nasogástrica está basada en un nivel de más bajo de cuidado por la naturaleza del diagnóstico indicado.

16.20- El pago aprobado por calorías-gramos es la cantidad mayor que Medicare aprueba según establecido en la prueba diagnóstica.

16.21 -El código de procedimiento fue cambiado para reflejar los servicios actuales rendidos.

16.22- Medicare no paga por servicios cuando la cantidad a cobrar no se indica.

16.23- Este cheque es por la cantidad en exceso que usted pagó para aplicar a un sobrepago anterior.

16.24- Servicios proporcionados abordo de un barco son cubiertos solamente cuando el barco está registrado en los Estados Unidos y está en aguas territotiales de los Estados Unidos. Además, el servicio debe ser proporcionado por un médico con licencia para practicar en los Estados Unidos.

16.25- Medicare no paga por tantos servicios o suministros.

16.26- Medicare no paga por servicios o artículos relacionados con procedimientos que no han sido aprobados ni facturados.

16.27- Este servicio no está cubierto porque nuestros archivos indican que usted estaba recluído en el hospital.

16.28- Medicare no paga por servicios o equipo que usted no recibió.

16.29- El pago fue incluido en otro servicio que usted recibió.

16.30- Hemos combinado los servicios facturados bajo un solo procedimiento.
16.31- Es su responsabilidad pagar al médico primario el costo mensual acordado.

16.32- Medicare no paga este servicio por separado.

16.33- Su pago incluye interéses debido a que Medicare excedió el tiempo límite para procesar la reclamación.

16.34- Usted no debería ser facturado por este servicio. Usted no tiene que pagar esta cantidad.

16.35- Usted no tiene que pagar esta cantidad.

16.36- Si usted ya lo ha pagado, tiene derecho a un reembolso de su proveedor.

16.37- Por favor vea al dorso de esta notificación.

16.38- No se incurre en cargos por días de ausencia.

16.39- Solamente un proveedor al mes puede ser pagado por este servicio. Ya se le ha pagado a otro proveedor por este servicio.

16.40- Solamente un servicio al día por paciente interno es aprobado.

16.41- El pago se está denegando porque ud. rehusó pedir un reembolso bajo sus beneficios de Medicare.

16.42- La determinación del proveedor de no existir cubierta es correcta.

16.43- Este servicio no puede ser aprobado sin un plan de tratamiento y supervisión de un médico.

16.44- Cuidados rutinarios no están cubiertos.

16.45- Usted no puede ser facturado separadamente por este artículo o servicio. Usted no tiene que pagar esta cantidad.

16.46- Los límites de pago de Medicare no afectan el derecho de los Indígenas Americanos al servicio gratis prestado en las Instituciones de Salud Indígena.

16.47- Cuando el deducible es aplicado a servicios psiquiátricos fuera del hospital, a usted le pueden facturar hasta la cantidad aprobada. La columna titulada "Podría Ser Facturado" le indicará la cantidad correcta que usted debe pagar a su proveedor.

SERVICIOS QUE NO FUERON PRESTADOS POR DOCTORES

17.1 - Servicios realizados por una enfermera privada no están cubiertos.

17.2 - Su médico debe facturar por este servicio de anestesia.

17.3 - Este servicio se denegó porque usted no lo recibió bajo la supervisión directa de un médico.

17.4 - Servicios realizados por un audiólogo no son cubiertos, excepto por procedimientos diagnósticos.

17.5 - El patrón de su proveedor debe enviar esta reclamación y estar de acuerdo en aceptar la asignación.

17.6 - Debido a que usted alcanzó su límite anual por este servicio, no se hará un pago completo.

17.7 - Este servicio debe ser realizado por un trabajador social clínico autorizado.

17.8 - El pago fue denegado debido a que usted alcanzó el pago máximo del beneficio.
17.9 - Este servicio es pagado por Medicare Parte A. El proveedor debe enviar su reclamación a ellos.

17.10- La cantidad aprobada ha sido reducida porque el anestesiólogo dirigió procedimientos médicos concurrentes.

17.11 -Este servicio no se puede pagar según facturado.

17.12- Este servicio no es cubierto cuando es proporcionado por un terapísta independiente.

17.13- Medicare aprueba hasta $_______ al año por servicios facturados por un terapísta ocupacional o físico.

17.14- Los costos por terapia de mantenimiento no están cubiertos.

17.15- Este servicio no puede ser pagado si no está certificado por su médico cada ( ) días.

CUIDADO PREVENTIVO

18.1 - Exámenes rutinarios y servicios relacionados no están cubiertos por Medicare.

18.2 - Esta inmunización y/o servicios preventivos no están cubiertos.

18.3 - Las pruebas de mamografía para mujeres menores de 35 años no están cubiertas.

18.4 - Este servicio se denegó debido a que no han transcurrido (12-24) meses desde su último examen de este tipo.

18.5 - Medicare pagará por otra mamografía en (12-24) meses.

18.6 - Una mamografía de cernimiento es cubierta una vez solamente para mujeres entre las edades de 35-39.

18.7 - El examen Papanicolau es cubierto una vez cada tres años, a menos de que existan factores de alto riesgo.

18.8 - Una mamografía de cernimiento es cubierta una vez cada 24 meses a mujeres de 40-49 años de edad que no tengan factores de alto riesgo.

18.9 - Una mamografía de cernimiento es cubierta una vez cada 12 meses a mujeres de 40-49 años de edad que tengan factores de alto riesgo.

18.10- Una mamografía de cernimiento es cubierta una vez cada 12 meses a mujeres de 50-64 años de edad.

18.11- Una mamografía de cernimiento es cubierta una vez cada 24 meses a mujeres de 65 años o más de edad.

18.12- El examen de mamografía de cernimiento se cubre una vez al año para mujeres de 40 años de edad o más.

18.13- Este servicio no está cubierto para beneficiarios menores de 50 años de edad.

18.14- Este servicio está siendo denegado ya que no han transcurrido (12,24,48) meses desde el último (examen/procedimiento) de esta clase.

18.15- Medicare solamente cubre este procedimiento para beneficiarios con alto riesgo de contraer cáncer en el colon.

18.16- Este servicio está siendo denegado ya que se ha hecho un pago por un procedimiento similar dentro del término de tiempo establecido.

18.17- Medicare paga por el examen Papanicolau y/o examen pélvico (incluyendo un examen clínico del pecho) solamente una vez cada tres años, a menos que existan factores de alto riego.

18.18- Medicare puede pagar por un examen Papanicolau y/o examen pélvico (incluyendo un examen clínico del pecho) solamente cuando el médico somete la reclamación con un código especial para el examen Papanicolau y/o con un código especial para el examen pélvico. Por favor, pídale a su médico que vuelva a enviar la reclamación con el código especial.

18.19- La información que tenemos en su caso no apoya la necesidad para más de un examen Papanicolau o examen pélvico (incluyendo un examen clínico del pecho) en tres años.

18.20- Medicare no paga por separado estos servicios, ya que el pago estaba incluido en nuestra asignación por otros servicios que usted recibió el mismo día.

SERVICIOS MEDICOS PRESTADOS EN UN HOSPITAL

19.1 - Servicios de un especialista establecido en un hospital no son cubiertos, a menos que exista un acuerdo entre el hospital y el especialista.

19.2 - El pago se redujo debido a que este servicio fue realizado en un hospital como paciente no ingresado en lugar de la oficina del médico.

19.3 - Solamente una visita al hospital o consulta por proveedor es permitido por día.

LIMITES EN LOS BENEFICIOS

20.1 - Usted ha utilizado todos sus días de beneficios por este periodo.

20.2 - Usted ha llegado a su límite de 190 días de servicios psiquiátricos de hospital.

20.3 - Usted ha llegado a su límite de 60 días de reserva vitalicia.

20.4 - ( ) de los días de beneficios usados fueron cobrados a sus beneficios de días de reserva vitalicia.

20.5 - Estos servicios no pueden ser pagados porque sus beneficios se han agotado.

20.6 - Los días usados han sido reducidos por el pago del asegurador de grupo primario.

20.7 - De sus 190 días por servicios de psiquiatría a los que tiene derecho, le quedan ____.

20.8 - Estos días han sido reducidos del total de sus días de beneficios como (paciente interno o de los días de beneficios de Hogar de Enfermería Especializada) para este periodo de beneficios.

20.9 - Los servicios recibidos después de mm/dd/yy no pueden ser pagados porque sus beneficios ya estaban agotados.

RESTRICCIONES A LA COBERTURA

21.1 - Servicios rendidos por un pariente inmediato o un miembro de la misma casa o familia no están cubiertos.

21.2 - El proveedor de estos servicios no es elegible para recibir pagos de Medicare.

21.3 - Este proveedor no estaba cubierto por Medicare cuando usted recibió los servicios.

21.4 - Servicios rendidos fuera de los Estados Unidos no son cubiertos. Consulte su Manual de Medicare para servicios recibidos en Canadá y Méjico.

21.5 - Servicios necesitados como consecuencia de una guerra no están cubiertos.

21.6 - Este servicio no está cubierto cuando es rendido, referido u ordenado por este proveedor.

21.7 - Este servicio debe ser incluido en su factura de paciente interno.

21.8 - Servicios rendidos usando equipo que no es aprobado por la Administración de Alimentos y Drogas no son cubiertos.

21.9 - Medicare no paga por servicios no autorizados fuera del plan de cuidado de la salud.

21.10- Un asistente cirujano no está cubierto por este servicio y/o fecha del servicio.

21.11- Este servicio no estaba cubierto por Medicare cuando usted lo recibió.

21.12- Este servicio de hospital no fue cubierto porque el médico de cabecera no era elegible para recibir beneficios de Medicare cuando los servicios fueron prestados.

21.13- Esta cirugía no está cubierta porque el médico no era elegible para recibir beneficios de Medicare cuando los servicios fueron prestados.

21.14- Medicare no puede pagar por este artefacto experimental porque la Organización para la Administración de Alimentos y Medicinas (FDA) no ha iniciado el periodo clínico de prueba.

21.15- Medicare no puede pagar por este artefacto experimental porque la Organización para la Administración de Alimentos y Medicinas (FDA) ha terminado el período clínico de prueba.

21.16- Medicare no paga por este artefacto experimental.

21.17- Su Proveedor sometió cargos no cubiertos por los cuales usted es responsable.

21.18- Este servicio no está cubierto cuando es ordenado o rendido por este proveedor.

RECLAMACIONES SEPARADAS

22.1 - Su reclamación fue separada para ser procesada. Los servicios restantes pueden aparecer en una notificación aparte.

CIRUGIA

23.1 - El costo del cuidado antes y después de cirugía o procedimiento está incluido en la cantidad aprobada por ese servicio.

23.2 - Cirugía plástica y servicios relacionados no están cubiertos.

23.3 - Medicare no paga por aditamentos quirurgicos de apoyo, excepto por vendajes primarios para injertos de piel.

23.4 - Un cargo separado no es permitido debido a que este servicio es parte del procedimiento principal de cirugía.

23.5 - El pago se redujo debido a que un médico diferente le prestó cuidados antes y después de la cirugía.

23.6 - Esta cirugía fue reducida debido a que fue realizada con otra cirugía el mismo día.

23.7 - No se puede pagar a un cirujano asistente en un hospital de enseñanza, a menos que un médico residente no esté disponible.

23.8 - Este servicio no se paga debido a que es parte del cargo total del cuidado de maternidad.

23.9 - El pago se redujo debido a que los cargos facturados no incluyeron el cuidado después de la operación.

23.10- El pago se redujo debido a que el procedimiento fue finalizado antes de que la anestesia fuera administrada.

23.11- No se puede pagar debido que la cirugía fue cancelada o aplazada.

23.12- El pago se redujo debido a que la cirugía fue cancelada después de que usted estaba preparado para la cirugía.

23.13- Debido que a usted lo prepararon para la cirugía y la anestesia fue suministrada, el pago completo se hará, a pesar de que la cirugía fue cancelada.

23.14- El asisente del cirujano debe enviar su reclamación por este servicio por separado.

23.15- La cantidad aprobada es menor porque el pago fue divido entre dos médicos.

23.16- Una cantidad adicional no es permitida por este servicio cuando es realizado en ambos lados (izquierdo y derecho) del cuerpo.

MENSAJES PARA AYUDAR A DETENER EL FRAUDE

24.1 - Proteja su tarjeta de Medicare como si fuera una tarjeta de crédito.

24.2 - No acepte ofertas de servicios o artículos de Medicare gratis o con descuentos.

24.3 - No acepte servicios o artículos de Medicare gratis que le ofrecen personas que visitan su hogar.

24.4 - Sólo su médico, quien conoce su historial de salud puede ordenarle equipo médico.

24.5 - Revise siempre su Resumen de Medicare. Asegúrese de que la información es correcta.

24.6 - No venda su número de Medicare o su Resumen de Medicare.

24.7 - No acepte servicios ni equipo médico gratis a cambio de número de Medicare.

24.8 - Esté alerta a avisos que digan "Este artículo está aprobado por Medicare" o "Sin gastos adicionales".

24.9 - Manténgase informado, lea su Resumen de Medicare. Asegúrese de que la información es correcta.

24.10- Manténgase informado, lea ambas partes de su Resumen de Medicare.

24.11- Esté alerta a los fraudes contra Medicare, como regalos a cambio de su número de Medicare.

24.12- Lea cuidaosamente su Resumen de Medicare y verifique las fechas, servicios y cantidades facturadas.

24.13- Asegúrese de leer todos los papeles que tenga que firmar al recibir servicios bajo Medicare.

24.14- Asegúrese que cualquier servicio o equipo médico que usted recibió fue ordenado por su médico.

TIEMPO LIMITE DE ENVIAR LA RECLAMACION

25.1 - Esta reclamación fue denegada debido a que fue sometida después del tiempo límite.

25.2 - A usted solamente se le puede facturar el 20 por ciento del costo total que hubiese sido aprobado.

VISION

26.1 - Exámenes de refracción visual no son cubiertos.

26.2 - Espejuelos o lentes de contacto son cubiertos solamente después de una cirugía de catarata o si le falta el lente natural de su ojo.

26.3 - Solamente un par de espejuelos o lentes de contacto es cubierto después de cirugía de catarata con inserción de lente.

26.4 - Este servicio no es cubierto cuando es realizado por este proveedor.

26.5 - Este servicio es cubierto solamente en si se realiza conjuntamente con una cirugía de catarata.

26.6 - El pago se redujo debido a que el servicio fue terminado prematuramente.

HOSPICIO

27.1 - Este servicio no es cubierto debido que usted está registrado(a) en un hospicio.

27.2 - Medicare no pagar por el cuidado temporero de paciente interno cuando ecxede (5) días consecutivos por cada ocasión.

27.3 - La certificación del médico solicitando servicios de hospicio no se recibió a tiempo.

27.4 - La documentación recibida indica que los servicios generales de paciente interno no estaban relacionados a la enfermedad terminal. Por lo tanto, el pago va a ser ajustado a la tarifa de cuidado rutinario en el hogar.

27.5 - El pago por el día que le dieron de alta del hospital se hará a la agencia de hospicio a la tarifa de cuidado rutinario en el hogar.

27.6 - La documentación indica que el nivel de cuidado era al nivel de cuidado temporero, no al nivel general de cuidado como paciente interno. Por lo tanto, el pago de Medicare va a ser ajustado a la tarifa de cuidado rutinario en el hogar.

27.7 - De acuerdo con los requisitos de hospicio de Medicare, el consentimiento para la elección del hospicio no fue firmado a tiempo.

27.8 - La documentación sometida no apoya que su enfermedad sea terminal.

27.9 - La documentación indica que su nivel de cuidado como paciente interno no fue razonable ni necesario. Por lo tanto, el pago va a ser ajustado a la tarifa de cuidado rutinario en el hogar.

27.10- La documentación indica que el nivel de cuidado continuo no fue rasonable ni necesario. Por lo tanto, el pago va a ser ajustado a la tarifa de cuidado rutinario en el hogar.

27.11- El proveedor facturó por error por los artículos de cuidado rutinario en el hogar o por los servicios recibidos.

ASIGNACION MANDATORIA

28.1 - Debido a que usted recibe beneficios de Medicaid, su proveedor debe estar de acuerdo en aceptar la asignación.

MSP

29.1 - No se pueden hacer pagos secundarios debido a que la información de su asegurador primario fue omitida o incorrecta.

29.2 - No se hizo ningún pago debido a que la cantidad que su asegurador primario pagó, cubrió la cuenta del proveedor.

29.3 - Los beneficios de Medicare fueron reducidos porque algunos de estos gastos fueron pagados por su asegurador primario.

29.4 - En el futuro, si usted envía reclamaciones a Medicare para pagos secundarios, favor de enviarlas a: (dirección contratísta MSP).

29.5 - Nuestros archivos indican que Medicare es su asegurador secundario. Esta reclamación deberá ser enviada a su asegurador primario. (Note: Use "Add-on" message as appropriate).

29.6 - Nuestros archivos indican que Medicare es su asegurador secundario. Servicios prestados fuera de su plan de salud no son cubiertos. Medicare pagará esta vez solamente porque usted no fue notificado previamente.

29.7 - Medicare no puede pagar por este servicio, pues lo realizó un proveedor que no es miembro de su plan patronal prepagado de salud. Nuestros archivos indican que a usted se le informó sobre esta regla.

29.8 - Esta reclamación fue denegada debido a que el servicio puede ser cubierto por el plan de compensación del trabajador. Solicite a su proveedor que envíe esta reclamación a ese seguro.

29.9 - Ya que los beneficios de su seguro primario han sido agotados, Medicare será su asegurador primario en este servicio que está relacionado con el accidente.

29.10- Estos servicios no se pueden pagar porque usted los recibió en o antes de recibir un pago del seguro de responsabilidad pública por esta lesión o enfermedad.

29.11- Nuestros archivos indican que un plan de seguro de automóviles o un seguro de otro tipo son primarios para este servicio. Envíe esta reclamación a su asegurador primario. (Note: Use "Add-on" message as appropriate.)

29.12- Nuestros archivos indican que estos servicios pueden estar cubiertos bajo el programa federal del Pulmón Negro (Black Lung). Comuníquese con el Labor Department, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828. (Note: Use "Add-on" message as appropriate.)

29.13- Medicare no pagará estos servicios debido a que pueden ser pagados por otra agencia gubernamental. Envíe esta reclamación a esa agencia. (Note: Use "Add-on" message as appropriate.)

29.14- El pago secundario de Medicare es ($). Esta es la diferencia entre la cantidad aprobada de ($) por el asegurador primario y la cantidad pagada de ($) por el asegurador primario.

29.15- El pago secundario de Medicare es ($). Esta es la diferencia entre la cantidad aprobada por el Medicare de ($) y la cantidad pagada por asegurador primario de ($).

29.16- Su asegurador primario aprobó y pagó ($) en esta reclamación. Por lo tanto no habrá pago secundario por el Medicare.
29.17- Su proveedor accedió a aceptar ($) como pago completo en esta reclamación. Su asegurador primario ya ha pagado ($) por lo que el pago de Medicare es la diferencia entre las dos cantidades.

29.18- La cantidad bajo la columna Podría Ser Facturado asume que su asegurador primario le pagó al proveedor. Si su asegurador primario le pagó a usted, entonces usted tiene la responsibilidad de

pagarle al proveedor la cantidad que su asegurador primario le pagó a usted más la cantidad que aparece en la columna Podría Ser Facturado.

29.19- La cantidad que aparece en la columna Podría Ser Facturado asume que su asegurador primario le pagó a usted. Si su asegurador primario le pagó al proveedor, entonces usted solamente tiene que pagarle al proveedor la diferencia entre la cantidad cobrada y la cantidad que el asegurador primario pagó.

29.20- La cantidad que aparece en la columna Podría Ser Facturado asume que su asegurador primario le pagó a usted. Si su asegurador primario le pagó a su proveedor, entonces usted solamente tiene que pagarle al proveedor la diferencia entre la cantidad que el proveedor acordó aceptar y la cantidad que su asegurador primario pagó.

29.21- La cantidad que aparece en la columna Podría Ser Facturado asume que su asegurador primario no pagó por este servicio. Si su asegurador primario pago por este servicio, la cantidad que a usted le pueden facturar es la diferencia entre la cantidad cobrada y el pago del asegurador primario.

29.22- La cantidad que aparece en la columna Podría Ser Facturado asume que su asegurador primario le pagó a usted. Si su asegurador primario le pagó al proveedor, entonces usted solamente necesita pagarle al proveedor la diferencia entre la cantidad que el proveedor puede cobrar legalmente y la cantidad que su asegurador primario pagó. Vea la nota ( ) para ver el límite de cargo legal.

29.23- No se puede hacer un pago porque ya fue hecho o por la compensación de trabajadores o por el Programa Federal de Enfermedad Pulmonar Minera.

29.24- No se puede hacer un pago porque ya fue hecho por otra entidad gubernamental.

29.25- Medicare pagó todos los servicios cubiertos no pagados por otro asegurador.

29.26- El pagador primario es ______________________________.

29.27- El pago de su grupo primario ha cumplido con el deducible y coaseguro de Medicare.

29.28- Su responsibilidad en esta reclamación ha sido reducida por la cantidad pagada por su asegurador primario.

29.29- Su proveedor está autorizado a cobrar un total de ($) en esta reclamación. Su asegurador primario pagó ($) y el Medicare pagó ($). Ud. es responsable por la porción restante de ($).

29.30- ($) del dinero aprobado por su asegurador primario ha sido acreditado a su deducible de Medicare Parte B (A). Ud. no tiene que pagar esta cantidad.

29.31- Favor de enviar la reclamación con la información omitida o incorrecta.

29.32- El pago secundario de Medicare es de ($). Ésta es la diferencia entre la cantidad límite aprobada por Medicare de ($) y la cantidad pagada por el asegurador primario de ($).

CARGOS RAZONABLES

30.1 - La cantidad aprobada está basada en un método especial de pago.

30.2 - El cargo permitido a la facilidad es mayor que la cantidad facturada.
30.3 - Su médico no aceptó la asignación por este servicio. Bajo la Ley Federal, su médico no puede cobrarle más de $. Si usted pagó más de esta cantidad, usted tiene derecho a un reembolso de su proveedor.

30.4 - Un cambio en el método de pago ha resultado en un pago reducido o ningún pago por este procedimiento.

AJUSTES

31.1- Esto es una corrección a una reclamación previamente procesada y/o a su deducible.

31.2 - Un pago ajustado fue procesado basado en una revisión telefónica.

31.3 - Esta notificación es enviada a usted como resultado de una petición de reapertura.

31.4 - Esta notificación es enviada a usted como resultado de su petición por una audiencia.

31.5 - Si usted no está de acuerdo con la cantidad aprobada por Medicare y $100 o más están en disputa (menos el deducible y coaseguro), puede solicitar una audiencia. Debe pedir esta audiencia dentro de 6 meses desde la fecha de esta notificación. Para llegar a los $100, puede combinar cantidades de otras reclamaciones que han sido revisadas. También puede presentar evidencia nueva. Favor de llamar al número indicado en la Sección de Servicios al Cliente si necesita información adicional sobre el proceso de la vista.

31.6 - Un pago ajustado fue hecho basado en una petición por la Organización de Revisión de Normas Profesionales.

31.7 - Esta reclamación fue previamente procesada bajo un número/nombre de Medicare incorrecto. Nuestros archivos han sido corregidos.

31.8 - Esta reclamación fue ajustada para reflejar el proveedor correcto.

31.9 - Esta reclamación fue ajustada debido a un error en facturación.

31.10- Este es un ajuste a un cargo procesado previamente. Es possible que esta notificación no refleje los cargos originalmente sometidos.

31.11- La notificación que enviamos previamente indicó que su médico no puede cobrar más de $________. Este pago adicional permite que su médico le facture a usted la cantidad completa cargada.

31.12- La notificación previamente enviada indicó la cantidad que a usted le pueden cobrar por este servicio. Este pago adicional cambió esa cantidad. Su médico no le puede cobrar más de $__________.

31.13- La cantidad pagada por Medicare ha sido reducida por ($) previamente pagado por esta reclamación.

31.14- Este pago es el resultado de una decisión de un juez de derecho administrativo.

SOBREPAGOS

32.1- ($) de este pago ha sido retenido para recuperar un sobrepago anterior.

CUIDADO QUIRURGICO AMBULATORIO

33.1 - El centro ambulatorio quirúrgico debe facturar por este servicio.

PATIENT PAID / SPLIT PAYMENT

34.1 - Del total de ($) pagados en esta reclamación, nosotros le estamos pagando a ud. ($) porque ud. le pagó a su proveedor más del 20 por ciento del coaseguro de los servicios aprobados por Medicare. La cantidad restante ($), fue pagada al proveedor.

34.2 - La cantidad en la columna Podría Ser Facturado ha sido reducida por la cantidad que usted le pagó al proveedor, cuando los servicios fueron prestados.

34.3 - Después de aplicar los reglamentos de Medicare y la cantidad que ud. le pagó al proveedor cuando los servicios fueron prestados, nuestros archivos indican que usted tiene derecho a un reembolso. Favor de comunicarse con su proveedor.

34.4 - Le estamos pagando a ud. ($) porque la cantidad que usted le pagó al proveedor fue más de lo que a usted se le puede facturar por cargos que Medicare aprueba.

34.5 - La cantidad que le debemos es ($). Medicare normalmente no imprime cheques por cantidades inferiores a $1.00. Esta cantidad será incluida en su próximo cheque. Si usted desea esta cantidad inmediatemente, por favor pongase en contacto con nosotros en la dirección o número de teléfono indicado en la sección "Información de Servicios al Cliente".

34.6 - Este cheque incluye la cantidad de ($) la cuál fue retenida en una reclamación anterior.

34.7 - Este cheque incluye una cantidad menor de $1.00 la cual fue retenida en una reclamación anterior.

34.8 - La cantidad que usted le pagó al proveedor por esta reclamación es mayor que la cantidad requerida. Usted deberá recibir un reembolso de $XX de su proveedor, la cual es la diferencia entre la cantidad que usted pagó y la que debió haber pagado.

CUBIERTA SUPLEMENTARIA/ MEDIGAP

35.1 - Esta información será enviada a su asegurador privado. Envíe cualquier pregunta con respecto a sus beneficios a ellos. Su asegurador privado es ________________________.

35.2 - Hemos enviado su reclamación a su asegurador de Medigap. Envíe cualquier pregunta con respecto a sus beneficios a ellos. Su asegurador de Medigap es ________________________.

35.3 - No se enviará copia de esta notificación a su asegurador de Medigap debido a que la información estaba incompleta o era inválida. Favor de someter una copia de esta notificación a su asegurador Medigap.

35.4 - No se enviará una copia de esta notificación a su asegurador Medigap debido a que su proveedor no es participante del programa de Medicare. Favor de enviar la notificación a su asegurador Medigap.

35.5 - No se envió esta reclamación a su asegurador privado. Ellos indicaron que no pueden hacer un pago adicional. Favor de dirigir sus preguntas relacionadas con sus beneficios a ellos.

35.6 - Su póliza suplementaria no es una póliza Medigap bajo las leyes/regulaciones del estado o federales. Es su responsabilidad radicar una reclamación directamente con su asegurador.

35.7 - Por favor no someta esta notificación a ellos.

RECLAMACIONES CUANDO SE ACEPTA ASIGNACIÓN

36.1 - Nuestros archivos indican que usted fue informado por escrito, antes de recibir el servicio, que Medicare no pagaría. Usted es responsable por esta cantidad. Si usted no está de acuerdo, usted puede pedir una revisión.

36.2 - Aparentemente, usted no sabia que nosotros no pagamos por este servicio, por lo tanto usted no es responsable. Si usted le pagó al proveedor por este servicio debe enviarnos lo siguiente: 1) Copia de ésta notificación; 2) Factura del proveedor; 3) El recibo o prueba de que usted le pagó. Debe enviar su petición por escrito dentro de 6 meses de la fecha de esta notificación. Servicios de este tipo prestados en el futuro serán su responsabilidad.

36.3 - Su proveedor ha sido notificado de su derecho a un reembolso si pagó por este servicio. Si usted no recibe un reembolso de este proveedor dentro de 30 días desde el recibo de esta

notificación, favor de escribir a nuestra oficina incluyendo copia de esta notificación. Su proveedor tiene el derecho de apelar esta decisión, la cual podría cambiar su derecho al reembolso.

36.4 - Este pago reembolsa la cantidad total que ud. le pagó a su proveedor por los servicios previamente procesados y denegados. Ud. tiene derecho a este reembolso porque su proveedor no le informó por escrito antes de prestarle el servicio(s) que Medicare no pagaría por el los servicio(s) denegado(s). En el futuro, usted tendrá que pagar por este servicio cuando sea denegado.

36.5 - Este pago le reembolsa a ud. la cantidad total a la que ud. tiene derecho por servicios previamente procesados y reducidos. Ud. tiene derecho a este reembolso porque su proveedor no le informó por escrito antes de prestarle el servicio que Medicare aprobaría una cantidad menor. En el futuro, ud. tendrá que pagar la cantidad total facturada cuando sea reducida.

36.6 - Medicare está pagando esta reclamación, solamente esta vez porque parece que ni ud. ni su proveedor, sabían que los servicios iban a ser denegados. En el futuro, pagos por este tipo de servicio serán su responsabilidad.

DEDUCIBLE/COASEGURO

37.1 - La cantidad aprobada ha sido aplicada a su deducible.

37.2 - Una parte de esta cantidad aprobada ha sido aplicada a su deducible.

37.3 - ( ) fue aplicado a su deducible de hospital.

37.4 - ( ) fue aplicado a su coaseguro de hospital.

37.5 - ( ) fue aplicado a su coaseguro de Instalación Enfermería Especializada.

37.6 - ( ) fue aplicado a su deducible de sangre.

37.7 - El deducible en efectivo de la Parte B no aplica a estos servicios.

37.8 - La cantidad de coaseguro incluye la limitación para el tratamiento de enfermedad mental de paciente ambulatorio.

37.9 - Usted ha cumplido con ($) de sus ($) del deducible de la Parte B para (año).

37.10- Usted ha cumplido con ($) de sus ($) del deducible de la Parte A cubiertos por este periodo de beneficios.

37.11- Usted ha cumplido con el deducible de la Parte B para (año).

37.12- Usted ha cumplido con el deducible de la Parte A por este periodo de beneficios.

37.13- Usted ha cumplido con el deducible de sangre para (año).

37.14- Usted ha cumplido con _______ pinta(s) de su deducible de sangre.

SECCION DE INFORMACIÓN GENERAL

38.1 - Si usted cree que Medicare ha sido facturado por algo que usted no ha recibido, por favor llame a nuestro número de teléfono de fraude (número etc.).

38.2 - Si a usted le ofrecieron artículos o servicios gratis, pero fueron facturados a Medicare, por favor llame a nuestro número de teléfono de fraude (número etc.).

38.3 - Si usted cambia de dirección, favor de llamar al "contractor's name" al "contractor's telephone number" y a la Oficina del Seguro Social al 1-800-772-1213.

SECTION 39-SPANISH "ADD-ON" MESSAGES

SECTION 40-SPANISH "MANDATED" MESSAGES

HHA - AGENCIA DE SERVICIOS DE SALUD EN EL HOGAR

41.1 - Medicare solamente paga por este servicio cuando es proporcionado en adición a otros servcios.

41.2 - Este servicio debe ser desempeñado por una enfermera psiquiátrica con los credenciales requeridos.

41.3 - La información médica no apoyó la necesidad para continuar los servicios.

41.4 - Medicare no considera que este artículo es apropiado para el uso en el hogar.

41.5 - Medicare no paga por artículos de comodidad ni de conveniencia.

41.6 - Este servicio no fue proporcionado bajo un plan de cuidado establecido por su médico.

41.7 - Medicare no considera este artículo como ortopédico ni como una prótesis.

41.8 - Basado en la información proporcionada, su enfermedad o su lesión no le impedía dejar su hogar sin ayuda.

41.9 - Los servicios proporcionados excedieron los que su médico ordenó.

41.10- Los pacientes elegibles para recibir beneficios de servicios de salud en el hogar de otra agencia gubernamental no son elegibles para recibir beneficios similares bajo Medicare.

41.11- Las instrucciones de su médico estaban incompletas.

41.12- El proveedor facturó por error por estos artículos o servicios de acuerdo al record médico.

41.13- El proveedor facturó por servicios o artículos no documentados en su record.

41.14- Este servicio o artículo fue facturado incorrectamente.

41.15- Esta información demuestra que usted puede hacerse cargo de su cuidado personal.

41.16- Para recibir el pago de Medicare, usted deberá tener una orden firmada por su médico antes de recibir los servicios.

PROJECTO ESPECIAL (DEMOSTRACIONES)

60.1 - (Name of Hospital) en cooperación con médicos en su área, están participando en una demostración de Medicare el cual utiliza un método de pago simplificado que combina todos los hospitales y médicos relacionados a sus servicios de hospital.
Este pago sencillo va a hacer el proceso de facturación más fácil mientras que mantiene el costo más bajo o al mismo nivel de como era bajo el sistema tradicional de pago.

60.2 - La cantidad total que Medicare aprobó por sus servicios de hospital es de $__________. $___________ es la cantidad de Medicare Parte A por sus servicios de hospital y $_________ es la cantidad de Medicare Parte B por sus servicios médicos (de los cuales Medicare paga el 80%). Usted es responsable por cualquier deducible y coaseguro presentado más abajo.

60.3 - Medicare pagó $_________ por servicios de hospital y por servicios médicos. Su deducible de la Parte A es $__________.
Su coaseguro de la Parte A es $__________.
Su coaseguro de la Parte B es $__________.

60.4 - Esta reclamación está siendo procesada bajo un projecto especial.