Notice of Exclusions from Medicare Benefits
Skilled Nursing Facility (NEMB-SNF)

Date of Notice:_____

NOTE: You need to make a choice about receiving these health care items or services.

It is not Medicare's opinion, but our opinion, that Medicare will not pay for the item(s) or service(s) described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare will not pay for a particular item or service does not mean that you should not receive it. There may be a good reason to receive it. Right now, in your case, **Medicare will not pay for –**

Items or Services:

We believe that Medicare will not pay, for the following reason. (See the reason checked off below.)

- ❑ No qualifying 3-day inpatient hospital stay.
- ❑ No days left in this benefit period.
- ❑ Care not ordered or certified by a physician.
- ❑ Daily skilled care not needed.
- ❑ SNF transfer requirement not met.
- ❑ Facility/Bed not certified by Medicare.
- ❑ Care not given by, nor supervised by, skilled nursing or rehabilitation staff.
- ❑ Items or services not furnished under arrangements by the skilled nursing facility.
- ❑ **Other**: _____
  _____

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself or through other insurance that you may have. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost:** $_____).
  Your other insurance is:_____

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN** AND **DATE** THIS NOTICE.

❑ **Option 1. YES** I want to receive these items or services and get an official Medicare decision about coverage. Please submit a claim, with any evidence supporting my need for these items or services, to Medicare for its official decision. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicare makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have.

I understand that I can appeal if Medicare decides not to pay. Medicare will send me notice of its official decision not to pay that explains its decision in my case. That notice will explain how I can appeal Medicare's decision not to pay. If I do not hear from Medicare about its official coverage decision within 90 days, I can telephone Medicare at: (_____)_____. TTY/TDD: (_____)_____.

❑ **Option 2. YES** I want to receive these items or services. Do NOT submit a claim to Medicare. I agree to be fully and personally responsible for payment of any amount for which my other insurance will not pay. I realize I cannot appeal to Medicare.

❑ **Option 3. NO** I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Patient's Name	Medicare # (HICN)
Signature of the patient or of the authorized representative	Date