Insert contact information here

Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice explains why your provider and/or health plan decided Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

Why your services are no longer covered

We reviewed your case and decided that Medicare coverage of your {insert type} services should end.

- **The facts used to make this decision:**

- **Detailed explanation of why your services are no longer covered, and the Medicare coverage rules used to make this decision:**

- **Specific plan policy used to make the decision (health plans only):**

To get a copy of the rules or guidelines used to make this decision, or a copy of the documents sent to the QIO, call us at {insert provider/plan toll-free telephone number}.