Center Name, Address & Phone Number:

Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current SKILLED NURSING FACILITY Services Will End:

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Skilled Nursing Facility services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO 1-888-317-0751 to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

  Plan contact information ____

  ____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

____ ____________________

Signature of Patient or Representative Date

Notice of Medicare Non-Coverage (NOMNC) CMS-10123
Supplemental Delivery Documentation

CONFIRMATION OF NOTICE BY TELEPHONE

If the Provider is unable to personally deliver a notice of non-coverage to a person acting on behalf of a beneficiary who is incompetent, then the provider should telephone the representative. Please apply the appropriate label on the NOMNC to document the conversation.

CONFIRMATION OF FOLLOW-UP NOTICE BY MAIL

If notice is communicated by telephone:

1. Place a dated copy of the annotated NOMNC in patient file.
2. Mail a NOMNC to the representative the day telephone contact is made

Notice was mailed on ______________________ by ______________________________
Date Center Representative

Via: US Mail Certified Mail Fed Ex Priority Mail
Tracking # (if applicable) __________________________________

CONFIRMATION OF REFUSAL TO SIGN

I confirm that the Notice of Medicare Non-Coverage was hand-delivered to the patient or the authorized representative, however the patient or authorized representative refused to sign the acknowledgement of receipt.

Name of person receiving notice____
Date of delivery: ___________________________ Time: _________________ AM PM

____ __________________________
Signature of Person Delivering Notice Date

____ __________________________
Signature of Witness to Delivery of Notice Date