CMS 批准的 C 部分福利說明範本

HMO，每月 EOB 版本

# General Instructions

This is a Centers for Medicare and Medicaid Services (CMS) approved Part C Explanation of Benefits (EOB) template. CMS views Part C EOBs as ad-hoc information materials; therefore, they are not subject to CMS review and approval. However, CMS reserves the right, as with other ad-hoc communication, to request and review a sample of the materials to ensure compliance with our requirements.

* This template is for organizations that choose to send monthly EOBs to non-dual eligible members.
* Plans are not required to send an EOB to dual eligible members.
* Plans are responsible for ensuring that members receive the notification of appeal rights within the timeframes specified by CMS. If notification with an EOB would hinder the plan’s ability to provide timely notification, it must be delivered separately, within the required timeframes specified in the MA program regulations.
* The monthly EOB must be sent to members each month there is claims activity, whether or not there is member liability.

**HPMS submission:**

* All plans may be required to submit a Part C EOB to HPMS. CMS will provide more information when available.

# Format Instructions

* Minor grammar or punctuation changes, as well as changes in font type or color, are permissible.
* Text and numbers must be in font size 12 or larger.
* With the exception of charts, which should generally be in landscape formation, either landscape or portrait may be used.
* With the exception of the chart that gives the details on claims, the remaining sections of the document are to be formatted as two‑column or three-column text (the main title of a section may extend beyond the first column) to keep line lengths easy to read. Plans may adjust the width of the columns in the template.
* The document may be printed double-sided and, in lieu of a paper mailing, may be sent electronically to members who elect the paperless format.
* The document must have a header or footer that includes the page number. In addition, plans may include any of the following information in the header or footer: member identifiers, month and year, title of the document.
* Charts that continue from one page to the next should be marked with “continue” at the bottom on the continuing page. In an actual EOB, rows of a chart should not break across the page. Note: in the template language in this document, rows sometimes break across a page because of the instructions and substitution text.

# Content Instructions

* CMS encourages MAOs to use the HCPCS code descriptors and American Medical Association’s CPT code descriptors, followed by the HCPCS or CPT billing code shown in parentheses. Other appropriate billing codes, such as ADA approved dental codes, Medicare revenue codes for in-patient facility claims, and other widely recognized code descriptors may also be used.
* When providing claim information, plans may use date ranges to combine multiple occurrences of a service or item into a single row.
* All claim information provided in the EOB must be HIPAA compliant to protect member health information.

**Claims that must be included within the EOB:**

* Plans must include all Part C claims processed during the reporting period, including all claims for Part A and Part B covered services, mandatory supplemental benefits, and optional supplemental benefits. If applicable, claims for optional supplemental benefits are to be displayed separate from medical and hospital claims. Information for all claims includes: billing codes and descriptors, amount providers have billed the plan, total cost (amount the plan has approved), plan’s share, and member’s share (your share). Any benefit information that cannot be included timely must be accounted for in a subsequent reporting period.
* For plans that need additional time to develop systems for obtaining cost information from capitated entities, we are delaying, until January 1, 2015, the required implementation of reporting applicable information in the “Total cost” and “Plan’s share” columns. In the interim period, in lieu of dollar amounts in the “Total cost” and “Plan’s share” columns, plans may state: “This rate has been pre-negotiated. For more information, please contact your health care provider.”

Instructions within the template:

* All black text is required information that must be included as shown in the attached EOB template.
* Italicized blue text in square brackets is instruction and guidance specifically for MA plans. This information is not to be included in the beneficiary’s EOB.
* Non-italicized blue text in square brackets is text to be inserted as applicable.
* The first time the plan name is mentioned, the plan type designation (i.e., HMO, PPO, etc.) must be included.
* When instructions say “*[insert month]*”, use a format that spells out the full name of the month, e.g., “January.”
* Plans should make every effort to use a reporting period that aligns with a complete calendar month, however, if your plan uses a reporting period that does not correspond exactly to a calendar month, you may substitute the date range for your reporting period (e.g., “1/1/12 to 2/3/12” OR “January 1 – February 3, 2013”) whenever instructions say to “*[insert month] [insert year]*.”

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| 每月報告 *[Insert month] [Insert Year]*  期間處理的醫療和醫院賠付  適用會員 *[insert member name]*  *[If desired, plans may also insert a member ID number and/or other member numbers typically used in member communications.]*  **此報告並非賬單：**   * 我們已處理賠付的月度報告會說明您接受了哪些護理、計劃已支付了什麼以及您已支付了多少自付費用（或預計將收取哪些費用）。 * 如果您欠付任何費用，您的醫生及其他醫療服務提供者會向您寄送賬單。 * 此報告僅涵蓋醫療和醫院護理。 *[MA-only plans omit the next sentence.]* 我們將單獨寄送 D 部分處方藥報告。 * 如果您發現可能是虛假賬單的可疑情況，您可以隨時致電 1-800-MEDICARE (1-800-633-4227) 報告。（聽障人士可致電 1-877-486-2048。）   *[Plans may include the member’s mailing address on this cover page.]* |  | [Insert plan name and/or logo]  *[Insert Federal contracting statement]*  *[Plans may insert their Web site URL]* |
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| *[Insert plan name]*會員服務部  如您有疑問，請致電我們：*[Insert phone number]*  我們可隨時提供幫助*[insert days and hours of operation]*。  僅聽障/語障人士可致電：*[Insert TTY/TDD number]* *[Plans may insert other Member Services numbers, e.g., a Spanish customer service number]*  --------------------------  [*Plans that meet the 5% threshold, insert:*此資訊也免費提供其他語言版本。請撥打上述電話號碼聯絡會員服務部。] 會員服務部[*plans that meet the 5% threshold, insert:*還]為不說英語的人士提供免費的翻譯服務。  *[Plans that meet the 5% threshold, insert the disclaimer about the availability of non-English translations in all applicable languages.]* |
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| 在此提供之福利說明為簡易摘要，並非完整之福利敘述。如需更多資訊，請聯絡本計劃。*[Omit terms in the following sentence that are not applicable to the plan:]* 福利、處方藥一覽表、藥房網絡、醫療服務提供者網絡、保費、共付額和共同保險每年都可能有所變化。  *[Insert material ID]*已接受 |

*[In the “totals” section, plans must insert the total amounts for all claims for Part A and Part B services and mandatory supplemental benefits. Amounts for claims for optional supplemental benefits should be excluded from the totals section.]*

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| **總計**  **適用於醫療和醫院賠付** | 提供者  向計劃  收取的金額 | 總費用 （計劃已批准的金額） | **計劃應支付** | **您應支付** |
| **當月總額**（對於從 *[insert reporting period start date]* 至 *[insert reporting period end date]* 處理的賠付） | $*[insert total billed amount for the reporting period]* | $*[insert total approved amount for the reporting period]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]* | $*[insert total plan share amount for the reporting period]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]* | $*[insert total member liability amount for the reporting period]* |
| ***[insert year]***（*insert reporting period end date]* 期間處理的所有賠付） **的總額** | $*[insert total billed amount for the year]* | $*[insert total approved amount for the year]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]* | $*[insert total plan share amount for the year]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:* 此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]* | $*[insert total member liability amount for the year]* |

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| *[Plans with no deductibles, omit this section.]*  **自付扣除金：**  *[Plans with an overall deductible insert the text below. If the plan has both an overall deductible and service category deductible(s), insert information about both deductibles.]*  對於大多數承保服務，本計劃僅在您支付年度計劃自付扣除金後才會支付其應承擔的費用。  截至 *[insert reporting period end date]*，您已支付 *[insert as applicable: [insert amount member has paid toward deductible if less than the full deductible amount] [*到 *OR* 全額的] *[insert deductible amount]* 年度計劃自付扣除金。  *[Plans are permitted, but not required, to include a graphic, such as the one shown below, to illustrate the member’s progress toward the deductible:*  *条形图图例 ($0 – $250)*  $0 $250  = 您的年度計劃自付扣除金]  *[Plans with service category deductibles, include the text below about each.]*  本計劃僅在您支付了自付扣除金後才會支付其應承擔的*[insert service category]*費用。  截至 *[insert reporting period end date]*，您已就*[insert service category]*支付了 *[insert as applicable: [insert amount member has paid toward deductible if less than the full deductible amount]* 到*OR*全額的*]* *[insert deductible amount]* 自付扣除金。  *[Plans are permitted, but not required, to include a graphic, such as the one shown below, to illustrate the member’s progress toward the deductible:*  *条形图图例 ($0 – $250)*  $0 $250  = 您的 *[insert service category*]] 的自付扣除金 |  | **年度限額 – 此限額為您提供了財務保護** | |
| 此限額指明了您最多需要為[*insert as applicable:*計劃承保的醫療和醫院服務*OR*承保的 A 部分和 B 部分服務]支付的「自付費用」（*[Delete references to deductibles, copayments, or coinsurance if not applicable for the plan:]*共付額、共同保險和您的自付扣除金）。  此年度限額稱為您的「自付費用最高金額」。它提供了您必須支付金額的上限， 但並未限制您可獲得多少護理。  您為[*insert service]* 支付的自付費用將不計入您的年度自付費用最高金額。這表示：   * 一旦您的自付費用達到上限，**您就不再為所有服務支付自付費用，*[insert, if applicable:[insert service]***除外。 * 您可繼續獲取*[insert as applicable:*承保的醫療和醫院服務*OR*承保的 A 部分和B 部分服務]，**本計劃將在該年剩下的時間內支付全部費用**。*[Insert if applicable:*您為不受 Medicare 承保的服務支付的自付費用不計入您的自付費用最高金額。] | 截至 *[insert reporting period end date]*， **您已支付了 *[insert amount paid toward MOOP as of reporting period end date]*** 自付費用，該費用計入承保服務的 *[insert MOOP amount]* 自付費用最高金額。  *[Plans are permitted, but not required, to include a graphic, such as the one shown below to illustrate the member’s progress toward the MOOP:*  **条形图图例 ($0 – $3,400)**  $0 $3,400] |

*[If there are no claims processed during the reporting period, omit the remainder of the document.]*

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| *[insert month] [insert year]* 期間處理的賠付詳情 | | |
| **仔細查閱有關您的賠付的資訊，看看是否正確？**   * 如果您存有任何疑問或認為可能出錯，請先致電醫生診室或其他服務提供者。要求他們說明賠付情況。 * 如您仍存有疑問，請致電會員服務部（電話號碼列於第 1 頁的方框中）。 | **您有權提出上訴或投訴**   * 提出上訴是要求我們*更改對您的保險作出的決定*的正式方式。如果我們拒絕賠付，您可提出上訴。如果我們批准賠付要求，但您不同意您為用品或服務支付的金額，您也可提出上訴。有關提出上訴的資訊，請致電會員服務部（電話號碼列於第 1 頁的方框中）。 | 請記住，此報告並非賬單：   * 如果您尚未支付「您應支付」下所示的金額，*請等到收到提供者發出的賬單再支付。* * 如果您收到*高於*「您應支付」下所示金額的賬單，請致電會員服務部聯絡我們（電話號碼列於第 1 頁的方框中）。 |

*[Plans may insert the first claim (or part of the claim) on this page or begin claims on the following page. Claims that continue from one page to the next should be marked with “continue” at the bottom of the page that continues. However, an individual row of a claim should not break across the page. Note: in the model language in this document, rows sometimes break across a page because of the instructions and substitution text.]*

*[Plans must insert information for all Part C claims processed during the reporting period, including all claims for Part A and Part B covered services, mandatory supplemental benefits, and optional supplemental benefits.]*

| ***[Insert name of provider]***  賠付號碼：*[Insert claim number]*  （*[Insert as applicable:*網絡內*OR* 網絡外*]*提供者） | 服務  日期 | 提供者向計劃收取的金額 | 總費用（計劃批准的金額） | **計劃應支付** | **您應支付** |
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| *[Show each service or item on a claim in a separate row. Although, date ranges may be used to combine multiple occurrences of a service or item into a single row, e.g., for claims related to inpatient services.*  *[Insert description of the service or item that was provided and its billing code. For example: “Air and bone conduction assessment of hearing loss and speech recognition (billing code 92557)”]*  *[As needed, insert explanatory notes, preceded by “NOTE”]*  *[If the service or item on the row is shown only to describe what was provided and is not billed separately, insert an explanatory note:*註：金額為 $0.00，因為此服務或用品的費用由本賠付的另一部分承保。] | *[Insert date of service, using x/x/xx format]* | $[*Insert billed amount for this service or item]* | $*[Insert approved amount for this service or item]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]*  *[Note: if service or item is approved, use amount approved by the plan for the total cost.]*  *[If service or item is denied, insert applicable denied amount and/or insert:* **被拒絕**  （請在下文查閱有關您的上訴權的資訊。）*]* | $*[Insert plan share amount for this service or item]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]* | $*[insert member liability amount for this service or item]*  *[Note: if service or item has been denied, use either the maximum potential liability or “$0.00” for the member liability amount, whichever is applicable.]*  *[If cost sharing is a coinsurance, insert:*  您需為[*insert as applicable:*從網絡內*OR*網絡外提供者處*]*獲取的服務支付總金額的*] [insert if applicable:*[*insert percentage]*%]  *[If cost sharing is a copayment, insert:*  您需為[*insert as applicable:*從網絡內*OR]*網絡外提供者處]獲取的服務支付 *[insert if applicable:*[*insert copayment amount]*  *[If the service is a preventive service that is covered at no cost under Original Medicare, add the following:*  （這是 Original Medicare 免費承保的預防性服務之一，本計劃免費為您承保此網絡內服務。）*]*  *[If the service or item shown on this row has been denied, and the amount in this column for “your share” is not zero, insert:*  該服務被拒絕，但您可能負有支付此金額的責任。請在下文查閱有關您的上訴權的資訊。] |
| *[Insert next item or service for the claim, using language described above]* |  |  |  |  |  |
| *[Insert next item or service for the claim, using language described above]* |  |  |  |  |  |
|  | **總計：** | **$[*Insert total billed amount for this claim]*** | **$[*Insert total approved amount for this claim]***  ***[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]***  *[If service or item is denied, insert applicable denied amount and/or insert:* **被拒絕**  （請在下文查閱有關您的上訴權的資訊。）*]* | **$[*Insert total plan share amount for this claim]***  ***[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]*** | **$[*Insert total member liability amount for this claim]***  *[Note: if service or item has been denied, use either the maximum potential liability or “$0.00” for the member liability amount, whichever is applicable.]*  *[If all items in the claim are subject to the same coinsurance percentage or copayment amount, plans may insert the coinsurance/copayment text in this total row rather than repeating the identical text in the rows for each item or service.]*  *[If more than one service or item is denied, plans may omit the denial language in this column from the claim item rows and insert it in this total row instead.]* |

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| *[If a service or item has been denied and there is member liability, include approved NDP language with the EOB or insert the following text below the denied claim:*  **關於您被拒絕的賠償需要瞭解的事項：** | | |
| * *[Plans may insert a denial reason.]* * 我們已全部或部分拒絕此賠付要求，**您有權提出上訴。**提出上訴是要求我們*改變拒絕您賠付要求的決定*的正式方式。如果我們同意改變我們的決定，即表示我們將批准賠付而非拒絕，我們將支付我們應承擔的部分。 * **提供者也可提出上訴，如果發生這種情況，您無需支付費用。**您可能想要聯絡提供者，以瞭解其是否會向我們提出上訴。如果提供者恰當地提出上訴，您將無須支付費用（正常的分攤費用除外），且您無需自行提出上訴。 | * **如果我們拒絕部分或全部的賠付，我們將寄給您一封信函**（「拒絕付款通知」），解釋服務或用品不受承保的原因。此信函也介紹了若您希望對我們的裁決提出上訴並要求我們重新考慮時，該如何處理。 * **重要提示：**如您沒收到此信函，請致電會員服務部聯絡我們（電話號碼列於第 1 頁的方框中）。 | * **如果您存有疑問或需要上訴幫助，您可聯絡：** * 我們的會員服務部 （電話號碼列於第 1 頁的方框中） * 1-800-MEDICARE  (1-800-633-4227)， 全天候服務。 （聽障人士可致電  1-877-486-2048。）] |

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| *[If a service or item has been denied and there is no member liability, insert the following text below the denied claim:*  **關於您被拒絕的賠償需要瞭解的事項：** | |
| * **註：我們已全部或部分拒絕此賠付要求。**但是，您無須負責支付賬單金額，因為您是從*[insert as applicable:* *[insert plan name]* 提供者處獲取此服務OR根據 *[insert plan name]* 提供者的轉診獲取此服務*].]* | * **如有疑問，您可聯絡：** * 我們的會員服務部（電話號碼列於第 1 頁的方框中） * 1-800-MEDICARE (1-800-633-4227)，全天候服務。（聽障人士可致電 1-877-486-2048。）] |

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| *[If the service or item in this row was previously denied and has now been approved on appeal, insert the following text below the claim:*  **有關您的賠付需要瞭解的事項：** | |
| * 註：我們最初拒絕了此[*insert as applicable:*用品*OR*服務]並收到了針對我們拒絕決定提出的上訴。[*Insert as applicable:*在審核上訴請求後，我們推翻了我們的拒絕決定，並批准了該[*insert as applicable:*用品*OR*服務]。*OR*我們的拒絕決定被推翻，此[*insert as applicable:*用品*OR*服務]現已獲批准。]這表示，[*insert as applicable:*用品*OR*服務獲承保，且計劃[*Insert as applicable:*已支付OR將支付]其應承擔的費用。] | * **如有疑問，您可聯絡：** * 我們的會員服務部（電話號碼列於第 1 頁的方框中） * 1-800-MEDICARE (1-800-633-4227)， 全天候服務。（聽障人士可致電  1-877-486-2048。）] |

*[If there are no claims for optional supplemental benefits processed during the reporting period, delete the remainder of this document.]*

*[If a claim for optional supplemental benefits was processed during the reporting period, it must be included in the EOB. Claims for optional supplemental benefits should appear after the claims for Part A and Part B services and mandatory supplemental benefits. Plans should include the section header provided below before the first claim for optional supplemental benefits. The format for the claims chart is provided below .In this section, deductible amounts may be included in the “Your share” column. Please note that the format is the same as for other Part C benefits, except for the additional text describing optional supplemental benefits which appears in the first column header.]*

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| 可選補充服務：*[insert month] [insert year]* 期間處理的賠付詳情  （第 2 頁所示的總額中**未**包括可選項補充服務的金額） |

| ***[Insert name of provider]***  賠付號碼：*[Insert claim number]*  （*[If applicable, insert: [Insert as applicable:*網絡內*OR*網絡外*]*提供者*[plans may add the type of optional supplemental benefits, e.g., “of dental services.”]*）*[Insert type of optional supplemental benefits]*是「可選項補充服務」。這些是您單獨支付保費的額外服務。 | 服務  日期 | 提供者向計劃收取的金額 | 總費用（計劃批准的金額） | **計劃應支付** | **您應支付** |
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| *[Show each service or item on a claim in a separate row.]*  *[Insert description of the service or item that was provided and its billing code. For example: “Air and bone conduction assessment of hearing loss and speech recognition (billing code 92557)”]*  *[As needed, insert explanatory notes, preceded by “NOTE”]*  *[If the service or item on the row is shown only to describe what was provided and is not billed separately, insert an explanatory note.*註：金額為 $0.00，因為此服務或用品的費用由本賠付的另一部分承保。] | *[Insert date of service, using x/x/xx format]* | $[*Insert billed amount for this service or item]* | $*[Insert approved amount for this service or item]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]*  *[Note: if service or item is approved, use amount approved by the plan for the total amount]*  *[If service or item is denied, insert applicable denied amount and/or insert:* **被拒絕**  （請在下文查閱有關您的上訴權的資訊。）*]* | $*[Insert plan share amount for this service or item]*  *[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]* | $*[insert member liability amount for this service or item]*  *[Note: if service or item has been denied, use either the maximum potential liability or “$0.00” for the member liability amount, whichever is applicable.]*  *[If cost sharing is a coinsurance, insert:*  您需為*[insert if applicable:*[*insert as applicable:* 從網絡內*OR*網絡外*]*提供者處]獲取的服務支付總金額的 [*insert percentage]*%  *[If cost sharing is a copayment, insert:*  您需為*[insert if applicable:[insert as applicable:*從網絡內*OR*網絡外]提供者處]獲取的服務支付 $[*insert copayment amount]* 的共付額  *[If there is a deductible charged for the service or item, insert:*  您需為該服務或用品支付 $[*insert copayment amount*] 的自付扣除金]  *[If the service or item shown on this row has been denied, and the amount in this column for “your share” is not zero, insert:*  該服務被拒絕，但您可能負有支付此金額的責任。請在下文查閱有關您的上訴權的資訊。] |
| *[Insert next item or service for the claim, using language described above]* |  |  |  |  |  |
| *[Insert next item or service for the claim, using language described above]* |  |  |  |  |  |
|  | **總計：** | **$[*Insert total billed amount for this period claim]*** | **$[*Insert total approved amount for this claim]***  ***[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]***  *[If service or item is denied, insert applicable denied amount and/or insert:* **被拒絕**  （請在下文查閱有關您的上訴權的資訊。）*]* | **$[*Insert total plan share amount for this claim]***  ***[Plans with capitated arrangements prior to January 1, 2015 may insert:*此費率是經過事先議定的。要瞭解更多資訊，請聯絡您的醫療保健提供者。*]*** | **$[*Insert total member liability amount for this claim]***  *[Note: if service or item has been denied, use either the maximum potential liability or “$0.00” for the member liability amount, whichever is applicable.]*  *[If all items in the claim are subject to the same coinsurance percentage or copayment amount, plans may insert the coinsurance/copayment text in this total row rather than repeating the identical text in the rows for each item or service.]*  *[If more than one service or item is denied, plans may omit the denial language in this column from the claim item rows and insert it in this total row instead.]* |

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| *[If a service or item has been denied and there is member liability, include approved NDP language with the EOB or insert the following text below the denied claim:*  **關於您被拒絕的賠償需要瞭解的事項：** | | |
| * *[Plans may insert a denial reason.]* * 我們已全部或部分拒絕此賠付要求，**您有權提出上訴。**提出上訴是要求我們*改變拒絕您賠付要求的決定*的正式方式。如果我們同意改變我們的決定，即表示我們將批准賠付而非拒絕，我們將支付我們應承擔的部分。 * **提供者也可提出上訴，如果發生這種情況，您無需支付費用。**您可能想要聯絡提供者，以瞭解其是否會向我們提出上訴。如果提供者恰當地提出上訴，您將無須支付費用（正常的分攤費用除外），且您無需自行提出上訴。 | * **如果我們拒絕部分或全部的賠付，我們將寄給您一封信函**（「拒絕付款通知」），解釋服務或用品不受承保的原因。此信函也介紹了若您希望對我們的裁決提出上訴並要求我們重新考慮時，該如何處理。 * **重要提示：**如您沒收到此信函，請致電會員服務部聯絡我們（電話號碼列於第 1 頁的方框中）。 | * **如果您存有疑問或需要上訴幫助，您可聯絡：** * 我們的會員服務部（電話號碼列於第 1 頁的方框中） * 1-800-MEDICARE  (1-800-633-4227)，全天候服務。（聽障人士可致電 1-877-486-2048。）] |

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| *[If a service or item has been denied and there is no member liability, insert the following text below the denied claim:*  **關於您被拒絕的賠償需要瞭解的事項：** | |
| * **註：我們已全部或部分拒絕此賠付要求。**但是，您無須負責支付賬單金額，因為您是從*[insert as applicable:* *[insert plan name]* 提供者處獲取此服務OR根據 *[insert plan name]* 提供者的轉診獲取此服務*]]* | * **如有疑問，您可聯絡：** * 我們的會員服務部（電話號碼列於第 1 頁的方框中） * 1-800-MEDICARE (1-800-633-4227)，全天候服務。（聽障人士可致電 1-877-486-2048。）] |

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| *[If the service or item in this row was previously denied and has now been approved on appeal, insert the following text below the claim:*  **有關您的賠付需要瞭解的事項：** | |
| * 註：我們最初拒絕了此[*insert as applicable:*用品*OR*服務]並收到了針對我們拒絕決定提出的上訴。[*Insert as applicable:*在審核上訴請求後，我們推翻了我們的拒絕決定，並批准了[*insert as applicable:* item *OR* service]。*OR*我們的拒絕決定被推翻，此[*insert as applicable:* item *OR* service]現已獲批准。]這表示，[*insert as applicable:* item *OR* service]獲承保，且計劃[*Insert as applicable:*已支付OR將支付其應承擔的費用。] | * **如有疑問，您可聯絡：** * 我們的會員服務部（電話號碼列於第 1 頁的方框中） * 1-800-MEDICARE (1-800-633-4227)，全天候服務。（聽障人士可致電 1-877-486-2048。）] |