**Insert contact information here**

**Detailed Explanation of Non-coverage**

|  |  |
| --- | --- |
| Date: | |
| Patient name: | Patient number: |

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined 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).

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

* **The facts used to make this decision:**
* **Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:**
* **Plan policy, provision, or rationale used in making the decision (health plans only):**

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: {insert provider/plan toll-free telephone number}

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