# 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}.