**[Insert Facility Name]**

**[Insert Facility Address]**

**[Insert Phone Number]**

**Notice Of Medicare Non-Coverage**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient name: | Patient ID number: | | |
| **The Effective Date Coverage of Your Current Home Health**  **Services Will End: [insert effective date]** | | | |
| * Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current home health 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 will also 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 that 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 an 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, **Livanta,** as follows to appeal, or if you have questions.   + - For residents in WI, MN, or IL, call 1-888-524-9900 or TTY 1-888-985-8775     - For residents in IA, call 1-888-755-5580 or TTY 1-888-985-9295   **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 for Members:**  **Quartz Medicare Advantage**  **Attn: Appeals Specialist**  **(800) 394-5566 or TTY:711 (or video relay service company of your choice)**  **Appeals Fax (608)644-3500**  **Plan contact information for Providers: Fax the completed Notice of Medicare non-Coverage to:**  **Quartz Medicare Advantage Utilization Management (608) 881-8397** | | | |
|  | | | |
| **Additional Information (Optional):**  If Phone Notification is needed: POA Name \_\_\_\_\_\_\_\_\_\_\_\_and Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_.  Contacted Date \_\_\_\_\_\_\_\_\_\_and time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  Last covered day \_\_\_\_\_\_\_\_\_Member Liability begins on\_\_\_\_\_\_\_\_\_\_\_\_\_.  Appeal Rights reviewed \_\_\_\_and QIO number provided\_\_\_\_\_\_.  Informed of date and time for expedited appeal\_\_\_\_\_\_.  Notice sent certified mail on or HCPOA will be in to sign on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  Facility Staff Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | |
| **Contact Information**  **Quartz Champion: (800) 394-5566 (TTY: 711).** You can reach us Monday through Friday, from 8 a.m.  to 8 p.m. October 1 - March 31, we’re also available Saturdays and Sundays from 8 a.m. to 8 p.m. | | | |
| **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** (signature and date to be completed by Patient or Representative) | |  | **Date** |
|  | |  | **Time** |

A close-up of a document

Description automatically generated

A document with text on it

Description automatically generated

A page of a document

Description automatically generated