PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

Agency or Skilled Nursing Facility Name ____
Agency or Skilled Nursing Facility Address ____
Agency or Skilled Nursing Facility Telephone____

Detailed Explanation of Non-coverage

Date:

Member name: Member 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:**
  [*Insert facts; Form is limited to one page*]

- **Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:**
  [*Insert explanation; Form is limited to one page*]

- **Plan policy, provision, or rationale used in making the decision (health plans only):**
  [*Insert policy/provision/rationale; Form is limited to one page*]

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: 855-339-8127, TTY: 711, 6am to 6pm, Monday through Friday.