# A black and white sign Description automatically generated with low confidence

# <Provider name, address, city, state, zip, phone>

# Detailed Explanation of Non-Coverage

Date: <date>

Patient name:<name> Patient number: <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:

<details of 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:

<explanation>

• Plan policy, provision, or rationale used in making the decision (health plans only):

<explanation>

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>

Form CMS-10124-DENC (Approved 12/31/2011) OMB Approval No. 0938–0953

A screenshot of text

Description automatically generated

A screenshot of text

Description automatically generated

