EXHIBIT 165

(Rev. 67, Issued: 10-18-10, Effective: 10-18-10, Implementation: 10-18-10)

NOTICE TO A PROVIDER THAT AGREEMENT WAS ACCEPTED

(**Date**)

Provider Name
Street Address
City, State, ZIP Code

Re: CMS CERTIFICATION NUMBER (CCN) [enter CCN assigned to the facility]

*Dear (**Provider Name**):*

Your agreement for participation as a (**identify type of provider**) under the Medicare program has been accepted by the Centers for Medicare & Medicaid Services (CMS). Your effective date of Medicare participation is (**date**). Enclosed is one copy of the completed agreement for your records.

Your participation is contingent upon compliance with all Federal civil rights requirements, as determined by the Office of Civil Rights.

Please include the CCN shown above on all forms and correspondence related to your Medicare participation.

Your Medicare Administrative Contractor (MAC) has been notified of your certification for Medicare participation. They will contact you shortly regarding billing procedures.

If you believe that this notice is incorrect in any aspect, you may request that it be reconsidered. The request for reconsideration must be submitted in writing to this office within sixty (60) days of receipt of this notice. You may submit any information that you believe has a bearing on the issue in question.

*If you have any questions, please contact (**Name and contact information of RO Staff**).*

We welcome your participation and look forward to working with you.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)

Enclosure: Form CMS-1561
Cc: State Survey Agency