EXHIBIT 165a

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

NOTICE TO A DEEMED PROVIDER/SUPPLIER
THAT AGREEMENT WAS ACCEPTED

*(**Date**)*

Provider /Supplier Name
Address
City, State, ZIP Code

*Dear (**Provider/Suppler Name**):*

*RE: CMS Certification Number (CCN) [**enter CCN assigned to the Facility**]*

*Your agreement for participation as a deemed status (**identify type of provider/supplier**) under the Medicare program has been accepted by the Centers for Medicare & Medicaid Services (CMS). This is based on the accreditation status granted by (Accreditation Organization) and its recommendation that you meet the applicable requirements for Medicare participation, based on its survey findings.*

*Your participation is contingent upon compliance with all Federal civil rights requirements as determined by the Office of Civil Rights. (**NOTE: Include this paragraph only for deemed providers, such as Hospitals, Critical Access Hospitals, Home Health Agencies and Hospices**.)*

*Your effective date of Medicare participation is (**date**). Enclosed is a copy of the completed agreement for your records.*

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.