EXHIBIT 252

(Rev. 30, 12-15-07)

MODEL REMINDER LETTER FOR FIRST REJECTION OF A REQUEST FOR MEDICARE APPROVAL OF ONE OR MORE ORGAN TRANSPLANT PROGRAMS

(Date)

Transplant Hospital Name
Address
City, State, Zip Code
Attn:

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

On (date) we sent you a letter requesting additional information regarding your application, for Medicare approval of your organ transplant program(s).

(fill in)

We have not received the information and want to remind you that the approval process cannot proceed without the missing information. The information requested with your application is:

_____ *Signature of hospital representative;*

_____ *Hospital name, address, phone and fax numbers, and e-mail;*

_____ *Hospital's National Provider Identification Number or;*
_____ *CMS Certification Number (Medicare I.D.);*

_____ *The type of transplant program for Medicare approval;*

_____ *Name of the designated primary transplant surgeon*
*(fill-in program)*_____*;*

_____ *Name of the primary transplant physician*
*(fill-in program)*_____*;*

_____ *Name of the OPO(s) with which the hospital has an agreement; and*

_____ *Other:* _____*;*

Your request cannot be processed until all the above information has been received by CMS. Please submit the information within 30 days to:

Centers for Medicare and Medicaid Services
Survey and Certification Group
7500 Security Blvd
Mailstop: S2-12-25
Baltimore, Maryland 21244

If you wish to withdraw your application or you have questions concerning missing information please contact Survey and Certification Group at 410-786-8476 or email to Sherry.Clark@cms.hhs.gov.

Sincerely,

Sherry Clark
Administrative Officer