Letter 1 - Model Hospital-Issued Notice of Noncoverage/HINN - Admission or Preadmission

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

The purpose of this notice is to inform you that we find that your admission for **(specify services or condition**) is not covered under Medicare **because (specify services to be furnished or condition to be treated) (specify)** is/are medically unnecessary **(or)** could be safely furnished in another setting. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss with your attending physician other arrangements for any further health care you may require. If you decide to **(be admitted to/remain in)** the hospital, you will be financially responsible for _____.[1]

This notice, however, is not an official Medicare determination. The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)**, and to make that determination.

- If you disagree with our conclusion: **(Select as appropriate)**

  Preadmission:

_____

[1] For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

- Request immediately, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

Admission:

- Request immediately, or at any point during your stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

- If you do not wish an immediate review:
  - You may still request a review within 30 calendar days from the date of receipt of this notice by telephoning or writing to the address specified below.
- Results of the QIO Review:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration and appeal rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment for all services beginning on **(specify date)**.[1]/
- QIO Address:

Name: _____

Address: _____

Telephone Number:_____

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

_____

[1]/ See footnote 1 on preceding page.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 2 - Model HINN Continued Stay (Attending Physician Concurs)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative — Admission Date

_____ _____

Address — Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code — Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for **(specify services or condition)** from (date of admission) through **(date of last day reviewed)**. Your attending physician has been advised and has concurred that beginning **(specify date of first noncovered day)** further **(specify services to be furnished or condition to be treated) (specify)** is/are medically unnecessary **(or)** could be furnished safely in another setting. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

You are financially liable for all costs for the care you receive, except for those services for which you are eligible under Part B beginning on **(specify date).**[1]/ If you leave on **(specify date)**[1], you will not be liable for costs for care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

However, this notice is not an official Medicare determination. The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)**, and to make that determination.

- If you disagree with our conclusion:
  - Request immediately, by noon of the first working day after receipt of this notice, an immediate review by telephone, or in writing. You may make this request through us or directly to the QIO at the address listed below.

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[1]/ For PPS hospitals and short term/acute care hospitals in waivered States, insert: the date of the third day following the date of receipt of the hospital notice.

For specialty hospitals and PPS exempt units, insert: the date of the day following the date of receipt of the notice.

- The QIO will request your views about your case and respond to you within one working day of receipt of your request and your medical records (sent by the hospital).

- If you do not request review by noon of the first working day after receipt of this notice:
  - You may still request QIO review at any point during your stay or within 30 days after you receive this notice, whichever is longer. Request this QIO review at the address listed below.
- QIO Review Results:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL:
    - You are responsible for payment for all services beginning **on (specify date)**[1]/ unless you have requested an immediate review.
    - If you request an immediate review (i.e., you make your request for review by noon of the first working day after receipt of this notice), you will not be responsible for payment until noon of the next day after you receive the QIO's notification.

- QIO Address:

  Name: _____

  Address:_____

  Telephone Number: _____

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

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[1]/ See footnote 1 on preceding page

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____	_____	_____
(Signature of beneficiary or person acting on behalf of beneficiary)	(Time)	(Date)

cc: QIO
Attending Physician

Letter 3 - Model HINN, Continued Stay-Swing Bed Only - (Attending Physician Concurs, Change from Acute to NF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for **(specify services or condition)** from **(date of admission)** through **(date of last day reviewed)**. Your attending physician has been advised and has concurred that beginning **(specify date of first noncovered acute care day) further (specify services to be furnished or condition to be treated) (specify)** is/are medically unnecessary **(or)** could be furnished safely in another setting. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

Upon receipt of this notice, the items and services you received will not be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

If you decide to stay in the hospital, you are financially liable for all costs of the care you receive except for those services for which you are eligible under Part B, beginning on **(specify date).**[1]/ If you leave the hospital on **(specify date)**, you will not be liable for costs of care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

- However, this notice is not an official Medicare determination. The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)** and to make that determination.

_____

[1]/ For PPS hospitals and short term/acute care hospitals in waivered States, insert the date of the third day following the date of receipt of the hospital notice.

For specialty hospitals and PPS exempt units, insert: the date of the day following the date of receipt of the notice.

If you disagree with our conclusion:

- Request immediately, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.

- If you do not request an immediate review:
  - You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.
- QIO Review Results:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL: You are responsible for payment for all services beginning on **(specify date)**[1]/

- QIO Address:

  Name: _____
  Address: _____
  Telephone Number: _____

Sincerely,

_____
Chairperson of Utilization Review
Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO
Attending Physician

_____

[1]/ See footnote 1 on preceding page.

Letter 4 - Model HINN- Continued Stay-Swing Bed Only (Attending Physician Concurs, Change from Acute to SNF Level of Care)

Hospital Letterhead

_____
Date of Notice

_____ _____
Name of Patient or Representative Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for **(specify services or condition)** from **(date of admission)** through **(date of last day reviewed)**. Your attending physician has been advised and has concurred that beginning **(specify date of first noncovered acute care day)**, you no longer need an acute level of care. You will begin to receive the type of hospital services which are furnished in a skilled nursing facility (SNF) beginning **(specify date of first SNF swing- bed day)**. This is known as SNF swing-bed services. Medicare will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days in the benefit period). However, this notice is not an official Medicare determination. The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)** and to make that determination.

- If you disagree with our conclusion and want an immediate review:
  - Request immediately, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.
- If you do not request an immediate review:
  - You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.
- QIO Review Results:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will continue to receive acute care services covered under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- IF THE QIO AGREES WITH THE HOSPITAL: you will continue to receive SNF swing bed services paid under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, or convenience services or items normally not covered by Medicare.

- QIO Address:

  Name: _____

  Address: _____

  Telephone Number: _____

Sincerely,

_____

Chairperson of Utilization Review Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital**) at **(time)** on **(date).** I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 5 - Model HINN- Continued Stay (QIO Concurs)

Hospital Letterhead

_____
Date of Notice

_____ _____
Name of Patient or Representative Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

We have reviewed the medical services you have received **for (specify services or condition)** from **(date of admission)** through **(date of last day reviewed)** and has determined that further hospitalization is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies/guidelines.

The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)**. The **(name of the QIO)** has concurred with our decision that beginning **(specify date of first noncovered day)** further **(specify)** services to be furnished (or) condition to be treated **(specify)** is/are medically unnecessary **(or)** could be safely furnished in another setting. You will also receive a notice from **(name of QIO)** confirming the review decision.

We have advised your attending physician of the denial of further inpatient hospital care. You should discuss other arrangements with your attending physician for any further health care you may require.

If you decide to stay in the hospital, you will be responsible for payment for all services provided to you by this hospital, except for those services for which you are eligible to receive payment under Part B, beginning **(specify date)**.[1]/

For specialty hospital and PPS-exempt units, insert the date specified by the QIO. The beneficiary's (or representative's) liability begins on the day following the date of receipt of the notice.

- If you disagree with this decision:
  - You may request by telephone or in writing an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

_____

[1]/ Insert: The date following the day of receipt of the hospital notice. For PPS hospitals and short term/acute care hospitals in waivered States, insert the date of the third day following the date of receipt of the notice.

Letter 5 (Cont.)

- If you do not request an expedited reconsideration:
  - You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by **(name of QIO).**
- QIO Reconsideration Results:
  - The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.
  - IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning **(specify date)**.
- QIO Address:

  Name: _____

  Address: _____

  Telephone Number: _____

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital**) at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO
Attending Physician

Letter 6 - Model HINN- Continued Stay - (QIO Concurs, Change from Acute to NF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

We have reviewed the medical services you have received for **(specify services or condition)** from **(date of admission)** through **(date of last day reviewed)** and has determined that further hospitalization paid under Medicare is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(Name of State)**. The **(name of QIO)** has concurred with our decision that beginning **(specify date of noncovered acute care day)** further **(specify services to be furnished or condition to be treated) (specify is/are)** medically unnecessary or could be safely furnished in another setting. You will also receive a notice from **(name of QIO)** confirming the review decision.

We have advised your attending physician of the denial of further acute hospital care. Upon receipt of this notice, the items and services which you receive will no longer be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on **(specify date)**.[1]/ You should discuss other arrangements with your attending physician for any further health care you may require.

- If you disagree with this decision and want an expedited reconsideration:
- You may request by telephone or in writing an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

Letter 6 (Cont.)

- If you do not request an expedited reconsideration:
  - You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by **(name of QIO**).
- QIO Reconsideration Results:
  - The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.
  - IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that you require acute care), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning **(specify date).** If you leave the hospital on **(specify date)**[1], you will not be liable for costs of care except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- QIO Address:
  Name:_____
  Address:_____
  Telephone: _____

Sincerely,

_____
Chairperson of Utilization Review
Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____
(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO
Attending Physician

_____

[1]/ Insert: The date following the day of receipt of the hospital notice. For PPS hospitals and short term/acute care hospitals in waivered States, insert the date of the third day following the date of receipt of the notice.

Letter 7 - Model HINN - Continued Stay (QIO Concurs, Change from Acute to SNF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for **(specify services or condition)** from **(date of admission)** through **(date of last day reviewed)** and has determined that acute care services are not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(Name of State)**. The **(name of QIO)** has concurred with our decision that beginning **(specify date of first noncovered acute care day)** you no longer require an acute level of care. You will begin to receive the type of hospital services which are rendered in a skilled nursing facility (SNF) beginning **(specify date of first SNF swing-bed day)**. This is known as SNF swing-bed services. The Medicare program will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days (100) in the benefit period).

- If you disagree with this decision and want an expedited reconsideration:
  - You may request by telephone or in writing an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.
- If you do not request an expedited reconsideration:
  - You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by **(name of QIO).**

Letter 7 (Cont.)

Page 2 - Hospital-Issued Notice of Noncoverage

- QIO Reconsideration Results:
  - The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.
  - IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that you do not require acute care), you will continue to receive SNF swing-bed services paid under Medicare. You will be responsible for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.
- QIO Address:

  Name: _____

  Address: _____

  Telephone Number: _____

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 9 - Model HINN - Direct Preadmission/Admission to NF Swing Bed

Hospital Letterhead

_____
Date of Notice

_____ _____
Name of Patient or Representative Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

The purpose of this notice is to inform you that we find that your admission for **(specify service or condition)** is not covered under Medicare because the services to be performed **(specify are not considered skilled care or constitute custodial care)**. This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss other arrangements with your attending physician for any further health care you may require. If you decide to **(be admitted to/remain in)** the hospital, you will be financially responsible for [1]/.

This notice, however, is not an official Medicare determination. The **(name of QIO)** is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of **(name of State)** and to make that determination.

- If you disagree with our conclusion and want an immediate review **(Select as appropriate)**

_____

[1]/ For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible to receive payment under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission (i.e., before 3:00 P.M.), insert: "customary charges for all services furnished after receipt of the hospital notice, except for those services for which you are eligible to receive payment under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the days following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

Letter 9 (Cont.)

Preadmission:

- Request immediately, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

Admission:

- Request immediately, or at any point during your stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

- If you do not wish an immediate review:
  - You may still request a review within 30 calendar days from the date of receipt of this notice by telephoning or writing to the address specified below.
- Results of the QIO Review:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration and appeal rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment for all services beginning on **(specify date).**[1]/ If you leave the hospital on **(specify date)**[1]/, you will not be liable for costs for care, except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- QIO Address:

  Name: _____

  Address: _____

  Telephone Number: _____

_____

[1]/ See footnote 1 on preceding page.

Letter 9 (Cont.)

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the **(name of hospital)** at **(time)** on **(date)**. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 10 - Model Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

We have has determined that you no longer require an acute (hospital inpatient) level of care. Because your doctor disagreed with this decision we are asking the quality improvement organization **(Name of QIO)** to review your case.

(Name of QIO) will contact you to solicit your views about your case and the care you need.

You do not need to take any action until you hear from the quality improvement organization.

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc