**EXHIBIT 193**

**MODEL LETTER INFORMING PPS-EXCLUDED HOSPITALS/UNITS THAT REVERIFICATION HAS BEEN APPROVED**

(**Date**)

Hospital Administrator Name
Name of PPS-Excluded Hospital or Hospital Containing PPS-Excluded Unit
Address
City, State, ZIP Code

Dear (**Hospital Administrator**):

I am pleased to inform you that (**name of hospital/unit**) is reverified for participation in the Medicare and Medicaid programs and will be excluded from the perspective payment system (PPS), effective (**enter effective date**).

This reverification is based on your self-attestation statement and checklist of (**date statement signed by the hospital/unit**) that to the best of your knowledge and belief the (**name of hospital/unit**) meets all of the applicable regulatory requirements found at (**42 CFR 412.23, 412.25, 412.27, 412.29 and/or 412.30 - enter whichever is directly applicable to the hospital/unit**).

Please be advised that the Centers for Medicare & Medicaid Services has authorized the State survey agency (SA) to conduct a validation survey of a sample of all PPS-excluded hospitals and units. The SAs will continue to conduct complaint surveys as in the past. If these surveys find that the hospital/unit did not in fact meet the applicable requirements for exclusion, Medicare payments will be made under PPS. In addition, if your hospital or unit undergoes any expansion or downsizing, or, if your hospital or unit no longer complies with our exclusion criteria, you are required to notify the SA immediately.

Sincerely,

Associate Regional Administrator, (**Region**)
(or its equivalent)