EXHIBIT 251

(Rev. 30, 12-15-07)

MODEL 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):***

Your request for Medicare approval of your organ transplant program(s)

(fill in)

was received by the Centers for Medicare & Medicaid Services (CMS) on (Date), however the following required information is needed to continue processing your application:

_____ *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

Any questions concerning missing information should be directed to Survey and Certification Group at telephone number 410-786-8476 or email to ***Sherry.Clark@cms.hhs.gov****.*

Sincerely,

Administrative Officer
Survey and Certification Group