# <Provider name, address, city, state, zip, phone>

# Detailed Explanation of Non-coverage

Date: <date>

Patient name: <name> Patient number: <number>

This notice explains why your provider and/or health plan decided Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

**Why your services are no longer covered**

We reviewed your case and decided that Medicare coverage of your <insert type> services should end.

* The facts used to make this decision:

<details of decision>

* Detailed explanation of why your services are no longer covered, and the Medicare coverage rules used to make this decision:

<explanation>

* Specific plan policy used to make the decision (health plans only):

<explanation>

To get a copy of the rules or guidelines used to make this decision, or a copy of the documents sent to the QIO, call us at {insert provider/plan toll-free telephone number}.

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