Appendix XIII-A — Notice Of Medicare Noncoverage

Patient Name:

The Effective Date Coverage of Your Current Services Will End:

- Your Medicare health plan and/or provider have determined that Medicare probably will not pay for your current services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: Livanta, 1-866-815-5440, TTD/TTY: 1-866-868-2289 to appeal, or if you have questions.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information:

Healthfirst Medicare Plan
Appeals & Grievances Unit
P.O. Box 5166
New York, NY 10274-5166T
Telephone: 1-877-779-2959
TDD/TTY: 1-888-542-3821

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____
Signature of Patient or Representative Date

Appendix XIII-B — Important Information for Healthfirst Medicare Plan Members' Appeal Rights

Healthfirst Medicare Plan

100 Church Street,

New York, NY 10007

If a member does not agree with a decision made by Healthfirst Medicare Plan, the member or the member's representative has the right to request a reconsideration. If the member believes that his/her health or ability to function could be seriously harmed by waiting 30 days for a service-related standard appeal, he/she may request an expedited 72-hour appeal. Healthfirst will decide if your request meets the requirements under Medicare guidelines. If not, the appeal will be processed under the standard 30-day appeal process.

To request an expedited 72-hour appeal (does not apply to denials of payment):

Telephone	**1-877-779-2959**	**Fax**	**1-646-313-4618**
Mail	**Healthfirst Appeals Unit P.O. Box 5166 New York, NY 10274**	**Visit**	**Healthfirst 100 Church Street New York, NY 10007**

To request a 30-day service-related appeal or a 60-day payment-related appeal:

A member can file a service-related appeal, which will be processed within 30 days, or a payment-related appeal, which will be processed within 60 days. The appeal can be submitted verbally or in writing.

In addition, the member may also file such appeal with the Department of Health and Human Services or the Railroad Retirement Board if the member is a railroad annuitant. Your request will be transferred to Healthfirst for processing.

Help With Your Appeal

Assistance with an appeal request is available at the New York City Department for the Aging, Health Insurance Information, Counseling and Assistance Program (HIICAP) Helpline at **1-212-442-1382**; the Medicare Rights Center at **1-888-466-9050 (1-888-HMO-9050);** Elder Care Locator at **1-800-677-1116**; or you can contact **1-800-633-4227** (**1-800-MEDICARE**), 24 hours/7 days. TTY/TDD users should call **1-877-486-2048.**

14-Day Extension

An extension up to 14 calendar days is permissible for both 30-day and 72-hour appeals, if the extension of time benefits the member; for example, if the member needs time to provide Healthfirst with additional information or if Healthfirst needs to have additional diagnostic tests completed.

Healthfirst will make a decision on the appeal and notify the member of it within 30 days for a standard appeal or within 72-hours for an expedited appeal from the date it is received. However, if our decision is not fully favorable, we will automatically forward the member appeal request to the Centers for Medicare & Medicaid Services' contractor, as well as the Center for Health Dispute Resolution (The Center), for an independent review. The Center will notify the member of its decision within the same time frames required of Healthfirst. An extension of up to 14 calendar days is also permitted under certain circumstances.

Appendix XIII-C — Standard Description and Instructions for Healthcare Consumers to Request an External Appeal

New York State Law ensures you the right to an external appeal when healthcare services are denied by your HMO or insurer (health plan) on the basis that the services are not medically necessary or that the services are experimental or still under investigation by the AMA.

To request an external appeal you must complete the application form and send it to the Department of Financial Services within

4 months of receipt of said notice of final adverse determination from your health plan in the first (1st) level of the plan's internal appeal process or within 4 months of receiving written confirmation from your health plan that the internal appeal process has been waived.
If all applicable items have not been completed, your request will not be accepted.

What is an External Appeal?

- An external appeal is a request that you make to the State for an independent review of a denial of services by your health plan.
- Reviews are conducted by external appeal agents who are certified by the State and have a network of medical experts to review your health plan's denial of services.
- You must complete the attached application and submit the application to the Department of Financial Services to request an external appeal.

Eligibility for an External Appeal

To be eligible for an external appeal:

- You must have received a final adverse determination as a result of your health plan's internal utilization review appeal process or you and your health plan must have agreed to waive that appeal process. A final adverse determination is written notification from your health plan that your healthcare service has been denied through the plan's appeal process. If your health plan offers two (2) levels of internal appeals, a final adverse determination is the determination of the first (1st) level appeal.
- If you and your health plan agree to waive the internal appeal process, the health plan must confirm the agreement in writing. You must submit a request for an external appeal to the State within 4 months from receipt of a notice of final adverse determination from your health plan or within 4 months of receiving written confirmation from your health plan that the internal appeal process has been waived. If your plan had two (2) levels of internal appeals, you must file a request for external appeal within 4 months of your receipt of the notice of final determination from the plan's first (1st) level appeal process to be eligible for an external appeal.
- If services are denied as experimental, you must have a life-threatening or disabling condition or disease to be eligible for an external appeal and your attending physician must complete the attached Attending Physician Attestation form and send the form to the Department of Financial Services.
- You may only appeal a service or procedure that is a covered benefit under your contract. The external appeal process may not be used to expand the coverage of your contract.
- Your health plan cannot be a self-insured plan. The State does not have jurisdiction over self-insured plans. Your employer can tell you if your plan is self-insured.
- The appeal cannot be for workers compensation claims or for claims under no-fault auto coverage.

What Happens If My Health Plan Offers a Second (2nd) Level of Internal Appeal?

- You will not be required to seek a second level of internal appeal with your health plan in order to request an external appeal.
- If you seek a second level of internal appeal with your health plan, you may not have time to request an external appeal. You must request an external appeal within 45 days of receiving the determination form your health plan's first level of internal appeal.

Am I Eligible For an External Appeal If I am Covered by Medicare or Medicaid?

- You are not eligible for this external appeal process when Medicare is your only source of health services. If you have coverage under Medicare, you must file a complaint with the Federal government for denials of services. Questions concerning Medicare coverage should be directed to the Centers for Medicare & Medicaid Services at 1-800-MEDICARE (1-800-633-4227).
- If you have coverage under Medicare and Medicaid, this external appeal process may be used solely to appeal denials of services or treatments covered by Medicaid.
- If you have Medicaid coverage you may also request a fair hearing. If you have requested an external appeal and a fair hearing,
  the determination in the fair hearing process will be the one that applies. If you have questions about the fair hearing process you should contact the New York State Department of Health at 1-800-774-4241.

Eligibility for an Expedited (fast-tracked) External Appeal

- If your attending physician attests that a delay in providing the treatment or service poses an imminent or serious threat to your health you may request an expedited appeal. When requesting an expedited appeal, make sure you give the attending physician an attestation from your primary care doctor to complete. Your appeal will not be forwarded to the external appeal agent until your physician sends this attestation to the Department of Financial Services.

How Long and External Appeal Will Take:

- Expedited appeals: The external appeal agent must make a determination within three (3) days of receiving your request for an external review from the State.
- Standard appeals: When your appeal is not expedited, the external appeals agent must make a determination within 30 days of receiving your request for an external review from the State. If additional information is requested, the external appeal agent has

  five (5) additional business days to make a determination.

The Cost to you for an External Appeal

Your health plan may charge you a fee of up to $50 for an external appeal.

- If you have coverage under Medicaid, CHPlus, or your health plan determines that the fee will pose a hardship, you will not be required to pay a fee.
- If your health plan does require a fee, you must submit the fee with your application for an external appeal. If you fax your application to the Department of Financial Services, you must send the fee within three (3) business days to the Department of Financial Services. If the fee is not sent to the Department of Financial Services within this timeframe, the external appeals agent will suspend review of your appeal until payment is received.
- Only checks or money orders, made payable to your health plan, will be accepted.
- If the external appeal agent overturns your health plan's determination, the fee will be refunded to you

When Information May be Submitted to the External Appeals Agent

- If your case is determined to be eligible for external review, you and your health plan will be notified of the certified external appeals agent assigned to review your case.
- Your health plan must send your medical and treatment records to the external appeal agent.our health plan must send your medical and treatment records to the external appeal agent.
- When the external appeals agent reviews your case, the agent may request additional information

from you or your doctor.
This information should be sent to the external appeals agent immediately.

- You and your doctor can submit information even when the external appeals agent has not requested specific information.
  You must submit this information within 45 days from when your health plan made a final adverse determination or from when you and your health plan agreed to waive the internal appeal process.

*** It is important to send this information immediately. Once the external appeals agent makes a determination or once your 45 days time period ends, you will be unable to submit additional information.

What Happens When an External Appeals Agent Makes a Decision?

- **Expedited appeals:** If your appeal was expedited, you and your health plan will be notified immediately by telephone or fax of the external appeal agent's decision. Written notification will follow.
- **Standard appealstandard appeals:** If your appeal was not expedited, you and your health plan will be notified in writing within two business days of the external appeals agent's decision.
- The decision of the external appeals agent is binding on you and your health plan.

If you have any questions, please contact the Department of Financial Services at: **1-800-400-8882** or the New York State Department of Health at **1-800-774-4241** or visit **http://www.dfs.ny.gov/insurance** or **www.health.state.ny.us.**

Appendix XIII-D — Attending Physician's Attestation for a Patient's External Appeal

(To be completed by the attending physician.)

Right to an External Appeal:

Patients may request an external appeal when an HMO or insurer has denied healthcare services on the basis of medical necessity or because services were considered experimental or investigational. Patients must request an external appeal within four (4) months of receiving a final adverse determination. Providers must file an external appeal within 60 days of the initial adverse determination.

The attending physician must complete this attestation and immediately fax it to the Department of Financial Services, at **1-800-332-2729**, in order for a patient to be eligible for an expedited or standard external appeal of an experimental or investigational determination or for an expedited external appeal of a medical necessity determination.

I Instructions

1. Items II, III, and V must be completed for all external appeal requests. In addition, item IV must be completed when services have been denied as being experimental or investigational.

II General Information

2. Name of Attending Physician completing this form:

   _____

   "Attending Physician" is defined as a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's/insured's life-threatening or disabling condition or disease. This physician is the one who recommended the service or treatment that is the subject of this request. For members who have HMO coverage without an out-of-network option, the attending physician must either participate in the member's health plan or must be a provider to whom the member's health plan referred the member.

3. Address: _____

_____

(city) (state) (zip)

4. Contact Person: _____
5. Phone Number: (____)_____Fax Number: (____)_____
6. Name of Patient: _____
7. Patient's Health Plan Member ID Number: _____

III Expedited Request for an External Review

8. A delay in providing the recommended health service would pose an imminent or serious threat to the health of the patient; therefore, an expedited determination (within three (3) days of the request) is necessary (please check one):

_____ YES _____ NO

IV To Request External Review of Experimental or Investigational Treatment Determinations

9. I hereby attest that (select a or b):
   a. _____ The patient has a life-threatening condition or disease which has a high probability of causing death.

   OR

   b. _____ The patient has a disabling condition or disease which renders the patient unable to engage in any substantial gainful activities by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or who, in case of a child under the age of eighteen (18), suffers from any medically determinable physical or mental impairment of comparable severity.

10. AND for which (please check one):

[ ] Standard health services or procedures have been ineffective or would be medically inappropriate.

[ ] There does not exist a more beneficial standard health service or procedure covered by the patient's health plan.

[ ] There exists a clinical trial that is open, that the patient is eligible to participate in, and into which the patient has been or will likely be accepted.

(Please note: the clinical trial must be a peer-reviewed study plan which has been:
(1) reviewed and approved by a qualified institutional review board; and
(2) approved by either of the National Institutes of Health (NIH), or an NIH cooperative group or an NIH center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the Federal Department of Veterans Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional review board of a facility which has multiple project assurances approved by the Office of Protection from Research Risks of the National Institutes of Health. The term "cooperative groups" means formal networks of facilities that collaborate on research projects and have established NIH-approved peer review programs operating within their groups and that include, but are not limited to, the National Cancer Institute (NCI) Clinical Cooperative Groups; the NCI Community Clinical Oncology Program; the AIDS Clinical Trial Groups; and the Community Programs for Clinical Research in AIDS.)

11. AND (select a or b):

a. _____ I have recommended a health service or procedure or a pharmaceutical product that, based on the following two (2) documents from the available medical and scientific evidence, is likely to be more beneficial to the patient than any covered standard health service or procedure.

Citation #1 (Describe the medical and scientific evidence relied upon, as defined below, and include publication name, issue number, and date, if available.)

Attach a copy of the document

Citation #2 (Describe the medical and scientific evidence relied upon, as defined below, and include publication name, issue number, and date, if available.)

Attach a copy of the document.

(Please note: medical and scientific evidence means the following sources: (a) peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; (b) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board; biomedical compendia; and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research; (c) peer-reviewed abstracts accepted for presentation at major medical association meetings; (d) peer-reviewed literature does not include publications or supplements to publications sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer; (e) medical journals recognized by the Secretary of Health and Human Services, under section 1861 (t) (2) of the federal Social Security Act; (f) the following standard reference compendia: (i) the American Hospital Formulary Service – Drug Information; (ii) the American Medical Association Drug Evaluation; (iii) the American Dental Association Accepted Dental Therapeutics; and (iv) the United States Pharmacopeia- Drug Information; (g) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Healthcare Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Healthcare Financing Administration, Congressional Office Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.)

OR

b. _____ I have recommended a clinical trial that is open, that the patient is eligible to participate in, and into which the patient has been or will likely be accepted.

V Attestation

I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____

Attending Physician's Name (please print clearly)

_____

Signature Date

This application should be faxed to the New York State Insurance Department at **1-800-332-2729**. If you have any questions, please contact the Insurance Department at **1-800-400-8882**.

Appendix XIII-E — Appointment of Representative Statement and Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB no. 0938-0950

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE

Form CMS-1696 (07/05) EF (07/05)

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-1696 (07/05) EF (07/05)

Appendix XIII-F — Detailed Notice of Discharge

DETAILED NOTICE OF DISCHARGE

OMB Approval No. 0938-1019

Patient Name:
Patient ID Number:
Date: Issued: _____
Physician:

DETAILED NOTICE OF DISCHARGE

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____. This is based on Medicare coverage policies listed below and your medical condition. **This is not an official Medicare decision.** The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k).)

  ____ Medicare Managed Care policies, if applicable (check below):
  ____ In response to your diagnosis, your physician developed a comprehensive care plan designed to specifically address your medical condition. Based on your progress and recovery thus far, your physician is confident that a sufficient level of inpatient services have been provided and has **not requested** additional inpatient days be added to your care plan.
  ____ Per Medicare guidelines, any additional inpatient days would need to be outlined under a plan of care and approved by a physician. As there is no current physician order for additional inpatient days, no additional services will be covered.

  ____ Other

  Specific information about your current medical condition:
  Some or all of the following factors no longer exist:
  ____ Severity of the signs and symptoms exhibited by the patient;
  ____ The medical predictability of something adverse happening to the patient;
  ____ The need for inpatient diagnostic studies;
  ____ Diagnostic and therapeutic services for medical diagnosis, treatment, and care are no longer medically necessary.

If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, or if you need help understanding the content of this notice, please call our Medical Management department at **1-888-394-4327 (**TTY **1-800-662-1220), Monday–Friday, 8am–6pm**.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10066 (approved 5/2007) H3359 UMD07_11
12/07

Appendix XIII-G — Important Message from Medicare About Your Rights

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

AN IMPORTANT MESSAGE FROM MEDICARE
ABOUT YOUR RIGHTS

As a Hospital Inpatient, you have the right to:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will be responsible for paying for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here {Insert Name and Telephone Number of the QIO}.

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

Talk to the hospital staff, your doctor, and your managed care plan (if you belong to one) about your concerns.

You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.

If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.

If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.

Step-by-step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call _____.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative Date

CMS-R-193 (approved 07/10)
1 of 3

Steps to Appeal Your Discharge

- **Step 1**: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

  Here is the contact information for the QIO:

  - **QIO Name**: _____
  - **Phone Number**: _____
  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun**.
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is:
    Hospital Name: _____

    Provider ID Number:
    _____

- **Step 2**: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

- **Step 3**: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.

- **Step 4**: The QIO will review your medical records and other important information about your case.

- **Step 5**: The QIO will notify you of its decision within **1 day after** it receives all necessary information.
  If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon (12pm) of the day after the QIO notifies you of its decision.

If you miss the deadline to appeal, you have other appeal rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  If you have Original Medicare: Call the QIO listed above.
  If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Notice Instructions: The Important Message From Medicare

Completing the Notice

Page 1 of the Important Message from Medicare

A. Header

Hospitals must display "Department of Health & Human Services, Centers for Medicare & Medicaid Services" and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: Fill in the patient's full name.

Patient ID Number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the patient's social security number.

Physician: Fill in the name of the patient's physician.

B. Body of the Notice

Bullet # 3. Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here _____.
Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

Page 2 of the Important Message from Medicare

First sub-bullet – Insert name and telephone number of QIO in bold: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials, date and time to document delivery of the follow-up copy of the IM, or documentation of refusals.