[Insert the sending entity's logo and contact information]

Detailed Explanation of Non-coverage

Date:<Date>

Patient name: <Member Name> Patient number: <Member ID>

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined 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).

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

• The facts used to make this decision:

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

• Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) at 1-877-273-IEHP (4347), 8:00 am to 8:00 pm, PST, 7 days a week, including holidays. TTY/TDD users should call 1-800-718-4347.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.