| | |
|---|---|
| **DEPARTMENT:** Regulatory Compliance Support | **POLICY DESCRIPTION:** Medicare – Hospital Issued Notice of Non-Coverage |
| **PAGE:** 1 of 6 | **REPLACES POLICY DATED:** 10/11/10, 4/15/13, 4/1/16, 1/1/18 |
| **EFFECTIVE DATE:** July 1, 2024 | **REFERENCE NUMBER:** REGS.GEN.010 |
| **APPROVED BY:** Ethics and Compliance Policy Committee | |

**SCOPE:** All Company-affiliated hospitals and entities performing and/or billing for hospital inpatient services.

Nursing
Admitting/Registration
Medical Staff
Medical Directors
Central Scheduling
Revenue Integrity
Billing Integrity
Reimbursement
Parallon Shared Service Centers
Patient Access
Parallon HIM Shared Services Centers (HSC)
Physician Office Staff
Physician Advisors
Ancillary Departments
Case Management
Advanced Practice Professionals

**PURPOSE:** To define the delivery and billing requirements for Hospital Issued Notices of Non-coverage (HINNs) for inpatient services not covered by Medicare fee-for-service.

**POLICY:**

1. Hospitals may issue HINNs to Medicare fee-for service inpatients if they plan to hold the patient financially liable. HINNs may be issued prior to admission, at admission, or at any point during an inpatient stay if it is determined that the care the patient is receiving, or is about to receive, is not covered because it is:
    a. Not medically necessary;
    b. Not delivered in the most appropriate setting; or
    c. Is custodial in nature.

2. Prior to issuing a HINN, hospitals may contact the ordering physician for additional information regarding the patient's case.

3. If there is ambiguity as to whether the requirements of a Medicare National or Local Coverage Determination (NCD or LCD, respectively) have been met, hospitals should proceed with obtaining an HINN in order to allow the Medicare Contractor to adjudicate the claim.

4. HINNs must not be issued to patients who are unable to comprehend the HINN, under duress, in a medical emergency, or in any case where the Emergency Medical Treatment and Labor Act (EMTALA) applies.

5. When notifying patients of Medicare non-covered services, hospitals must use the form that best represents the scenario of non-coverage. The hospital must adhere to the general guidelines and the specific guidelines applicable to the form being issued.

6. Services for which HINNs are issued must be billed in accordance with the requirements within this policy.
7. If a proper HINN is not obtained for an inpatient service determined not to be reasonable and necessary, the patient cannot be held financially liable.

**APPLICABLE HINN FORMS:**

**Preadmission/Admission HINN (Appendices AE and AS):** Use this HINN when a physician has ordered an inpatient admission that Medicare usually pays for, but in this case is not considered reasonable and necessary and the patient/physician intends to proceed with the admission. For example, the admission is non-covered as a result of not meeting the requirements of NCD/LCD or not meeting an inpatient level of care.

**HINN 10 - Notice of Hospital Requested Review (HRR) (Appendices BE and BS):** Use this HINN to request a Quality Improvement Organization (QIO) review/decision when the hospital determines that the patient no longer needs inpatient care, but is unable to obtain the agreement of the physician.

**HINN 11 (Appendices CE and CS):** Use this HINN when a diagnostic or therapeutic item or service that is not medically necessary will be provided during an otherwise covered inpatient stay. A HINN 11 may only used when a published Medicare coverage policy (NCD or LCD) confirms that the item or service is not medically necessary. A HINN 11 must not be issued for non-medically necessary items or services that are bundled into or integral to payment or treatment for diagnoses/reasons justifying covered inpatient stay.

**HINN 12 (Appendices DE and DS):** Use this HINN when a patient initially met an inpatient level of care, but the hospital, with the concurrence of the physician or QIO, determines that the patient no longer needs inpatient care, and has made the decision to discharge the patient.

**PROCEDURE:**

**ISSUING A HINN**

When the decision has been made to issue a HINN, the hospital must use the HINN that is appropriate to the situation as described above. The hospital must also adhere to the following guidelines for issuing a HINN:

- Use exact language as specified in CMS model forms (Appendices A-D)
- Issue on legal or letter size paper
- Utilize Times New Roman, 12 point font (18 point font for title)
- Print with dark ink on a pale background
- Handwrite insertions legibly
- Type insertions in 10-12 point font
- Do not use bolding, italics or highlighting other than those in CMS model forms

- Insert hospital letterhead and/or contact information
- Complete all blanks
- Deliver in-person to patient or representative*
  - Ensure comprehension by patient or representative
  - Obtain patient or representative signature (and date)
- Annotate if patient or representative refuses to sign
- Provide a copy to the patient, retain a copy on file in medical record and provide a copy to Medicare Contractor or QIO upon request.

*If the patient's representative is not physically present, the hospital should communicate financial responsibility information by telephone and receive the representative's agreement for financial liability. The hospital must maintain documentation that this was communicated, understood and agreed upon by the patient's representative.

**Preadmission/Admission HINN:**

- When issuing the HINN prior to the inpatient admission, the hospital must:
  - Complete and deliver the form as described above.
  - Inform the patient that they will be liable for all services, except those services eligible for payment under Part B.
  - Inform the patient they have a right to a QIO review, but they should do so immediately or no later than 3 days post receipt of the HINN.
- When issuing the HINN at 3pm or earlier on the day of admission, the hospital must:
  - Complete and deliver the form as described above.
  - Inform the patient that they will be liable for all services rendered after receipt of notice, except those services eligible for payment under Part B.
  - Inform the patient that they have a right to a QIO review, but they should do so immediately or at any point during their stay after the HINN has been issued.
- When issuing the HINN after 3pm on the day of admission, the hospital must:
  - Complete the form as described above.
  - Inform the patient that they will be liable for all services rendered on the day following receipt of notice, except those services eligible for payment under Part B.
  - Inform the patient they have a right to a QIO review, but they should do so immediately or at any point during their stay after the HINN has been issued.

**HINN 10 - Notice of Hospital Requested Review (HRR):**

- When the hospital requests a QIO review, it must supply any pertinent information to the QIO by close of business on the first full day immediately following the day the request was submitted.
- The QIO must:

- notify the hospital of receipt of request and if it has not received pertinent records;
- make a determination within 2 days of request; and
- notify the beneficiary, hospital and physician by telephone and subsequently in writing of its decision.

- The hospital should follow-up with the QIO if the above-specified items are not executed by the QIO.
- If the QIO concurs with the hospital, the hospital must issue a HINN 12.

**HINN 11:**

- When issuing the HINN, the hospital must:
  - Complete and deliver the form as described above;
  - Inform the patient that he/she will be liable for all non-covered services; and
  - Inform the patient of his/her right to a Medicare Contractor (FI/MAC or QIO) review.

**HINN 12:**

- When the physician concurs that inpatient care is no longer necessary and the patient did not request a QIO review by midnight of the proposed discharge and chose to remain in the hospital, the hospital must:
  - Complete and deliver the form as described above; and
  - Inform the patient that he/she will be liable for charges incurred as of midnight on the day of the proposed discharge.
- When the QIO has concurred that inpatient care is no longer necessary and the patient chooses to remain in the hospital, the hospital must:
  - Complete and deliver the form as described above; and
  - Inform the patient that he/she will be liable for charges incurred after 12 noon on the day after the verbal determination was made by the QIO.

**BILLING**

Individuals issuing HINNs must establish a mechanism to communicate pertinent information to the billing office.

**Preadmission/Admission HINN:**
When the entire stay has been determined to be not reasonable or necessary, and a proper Preadmission/Admission HINN was issued, the UB claim form must include:

- Occurrence code 31 (and date) in FL 34-34 to indicate the date the hospital notified the beneficiary.
- Occurrence span code 76 (and dates) in FL 35-36 to indicate the period of non-covered care for which the hospital is charging the patient.
- Occurrence span code 77 (and dates) in FL 35-36 to indicate any period of non-covered

care for which the provider is liable (e.g., the period between issuing the HINN and the time when the provider may begin to charge the patient).
- Value code 31 (and amount) in FL 39-41 to indicate the amount of non-covered charges to be billed to the patient. This amount is also reported as non-covered in FL 48 of the UB.

**HINN 11:**
Non-covered diagnosis codes, procedure codes, and related charges must be removed from payable type of bill 11X. If the hospital issued a proper HINN and will submit non-covered charges for denial, the non-covered charges must be split to a separate no-pay claim (type of bill 110). The no-pay claim must be billed with same from and through dates as the payable type of bill for the same stay. The UB claim form for the non-covered services must include:
- Occurrence code 32 (and date) in FL 31-34 to indicate the date the hospital provided the HINN to the patient
- Value code 31 (and amount) in FL 39-41 to indicate the amount of non-covered charges to be billed to the patient. This amount is also reported as non-covered in FL 48 of the UB.

**HINN 12:**
When a continued inpatient stay has been determined to be not reasonable and necessary and a proper HINN has been issued, the UB claim form must include:
- Occurrence code 31 (and date) in FL 34-34 to indicate the date the hospital notified the beneficiary.
- Occurrence span code 76 (and dates) in FL 35-36 to indicate the period of non-covered care for which the hospital is charging the patient.
- Occurrence span code 77 (and dates) in FL 35-36 to indicate any period of non-covered care for which the provider is liable (*e.g.*, the period between issuing the HINN and the time when the provider may begin to charge the patient).
- Value code 31 (and amount) in FL 39-41 to indicate the amount of non-covered charges to be billed to the patient. This amount is also reported as non-covered in FL 48 of the UB.

## EDUCATION

All individuals, including but not limited to case managers, registrars, Patient Access and the Medical Staff who are responsible for ordering, scheduling, registering and/or billing inpatient services must be educated on the contents of this policy.

## AUDIT and MONITORING

Internal Audit will incorporate the review of HINNs in their normal audit process. Regulatory Compliance Support and the Shared Services Division will develop a monitoring process that the hospitals, SSCs and MSCs can use to assess compliance with this policy.

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| **DEPARTMENT:** Regulatory Compliance Support | **POLICY DESCRIPTION:** Medicare – Hospital Issued Notice of Non-Coverage |
| **PAGE:** 6 of 6 | **REPLACES POLICY DATED:** 10/11/10, 4/15/13, 4/1/16, 1/1/18 |
| **EFFECTIVE DATE:** July 1, 2024 | **REFERENCE NUMBER:** REGS.GEN.010 |
| **APPROVED BY:** Ethics and Compliance Policy Committee | |

The Facility Ethics and Compliance Committee is responsible for implementation of this policy within the facility.

**REFERENCES:**

1. Medicare - National and Local Coverage Determinations Policy, REGS.GEN.011
2. CMS Beneficiary Notices Initiative (BNI) website (www.cms.gov/BNI)
3. HINN 11 Model Language and Instructions
4. Instructions for Completion of the HINN 12
5. Medicare Claims Processing Manual, Chapter 1, Sections 60 – 60.5, 150 – 150.2.3
6. Medicare Claims Processing Manual, Chapter 3, Section 40.2.2
7. Medicare Claims Processing Manual, Chapter 30, Sections 200.3.1, 220 – 220.5, 240 – 240.6
8. 42 CFR 405.1206
9. 42 CFR 412.42 (c) and (d)
10. 42 CFR 482.30

**Appendix AE: Model Language for Preadmission/Admission Hospital Issued Notice of Non-coverage**

Hospital Identifier

Preadmission or Admission Hospital-Issued Notice of Non-coverage (HINN)
Model Language

Name of Patient: _____Name of Physician:_____

Patient ID Number: _____Date Issued: _____

We believe that Medicare is not likely to pay for your admission for _____*(specify service or condition)*_____ because:

____it is not considered to be medically necessary

____it could be furnished safely in another setting

____other_____.

However, this notice is not an official Medicare decision.

**If you disagree with our finding:**

- You should talk to your doctor about this notice and any further health care you may need.
- You also have the right to an appeal, that is, an immediate review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to make a formal decision about whether your admission is covered by Medicare. **See page 2 for instructions on how to request a review and contact the QIO.**
- **If you decide to go ahead with the hospitalization, you will have to pay for:**

_____(*insert information from footnote 1 below)*_____

CONTINUED ON PAGE 2

1 For preadmission notices, insert: "customary charges for all services furnished during the stay, except for those services for which you are eligible under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

**If you want an immediate review of your case:**
*(insert one of the following as appropriate)*

*Preadmission:*

- *Call the QIO immediately at the number listed below, but no later than 3 calendar days after you receive this notice. If you are admitted, you may call the QIO at any point in the stay.*

*Admission:*

- *Call the QIO immediately at the number listed below or you may call the QIO at any point during your stay.*
- *You may also call the QIO for quality of care issues.*

**QIO Contact Information:** *(insert name of QIO in bold)*
*(insert telephone number of QIO)*

**If you do not want an immediate review:**

- You may still request a review within 30 calendar days from the date of receipt of this notice by calling the QIO at the number below.

**Results of the QIO Review:**

- The QIO will send you a formal decision about whether your hospitalization is appropriate according to Medicare's rules, and will tell you about your reconsideration and appeal rights.
    - IF THE QIO FINDS YOUR HOSPITAL CARE IS COVERED, you will be refunded any money you may have paid the hospital except for any applicable copays, deductibles, and convenience items or services normally not covered by Medicare.
    - IF THE QIO FINDS THAT YOUR HOSPITAL CARE IS NOT COVERED, you are responsible for payment for all services beginning on *(specify date)*. (see footnote1 on page 1).

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

Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

Signature of Patient or Representative | Date | Time

**Appendix BE: Model Language for Notice of Hospital Requested Review**

Hospital Identifier

Model Notice of Hospital Requested Review (HRR)

Name of Patient: _____Name of Physician:_____

Patient ID Number: _____Date Issued:_____

---

We believe that Medicare will not continue to cover your hospital care because these services are no longer considered medically necessary in your case. Because your doctor disagreed with our finding, the hospital is asking the quality improvement organization (QIO) to review your case. The QIO is an outside reviewer hired by Medicare to look at your case to decide if you are ready to leave the hospital. The name of the QIO is *(insert the name of the QIO)* .

- The QIO will contact you to solicit your views about your case and the care you need.
- You do not need to take any action until you hear from the QIO.

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

The QIO contact information was last updated in August 2014 and details can be found at the following link: http://www.qioprogram.org/.

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Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

_____ _____ _____

Signature of Patient or Representative Date Time

**Appendix CE: Model HINN 11- Non-covered Service(s) during Covered Stay**

*INSERT HOSPITAL LETTERHEAD AND/OR CONTACT INFORMATION*

| | |
|---|---|
| Name of Patient or Representative | Date of Notice |
| Street Address | Admission Date |
| City, State, Zip Code | Attending Physician |
| Health Insurance Claim (HIC) Number | |

**YOUR IMMEDIATE ATTENTION IS REQUIRED**

The purpose of this notice is to inform you that: *(BLANK 1 - SERVICE NAME)* is/are not covered under Medicare because: *(BLANK 2 - REASON FOR NONCOVERAGE)*.

Our opinion was based upon the following Medicare policy we and our Medicare intermediary follow: *(BLANK 3 - JUSTIFICATION OF ASSESSMENT OF NONCOVERAGE)*.

**If you decide to receive the service(s) listed above, based on our customary charges for this/these service(s), you will have payment responsibility for:** *(BLANK 4 - PATIENT FINANCIAL RESPONSIBILITY)*. Your attending physician has been advised of our opinion. You should talk with your physician about your health care needs, including the service(s) listed above.

**RECEIPT OF THIS NOTICE**

This notice is not an official Medicare decision. Your signature below only shows you have received the notice and understand what you may have to pay for. **On the next page is information to use if you get the service(s) and you want to ask Medicare if it agrees with our opinion.** Note we will also give a copy of this notice to your physician listed above.

| | |
|---|---|
| Signature of Beneficiary or Representative | Date |

**YOUR RIGHT TO A MEDICARE REVIEW (APPEAL):**

**You can ask us to file a Medicare claim for the service(s) listed on this notice. You will receive a Medicare Summary Notice (MSN) telling you Medicare's payment decision on this/these service(s), and how to ask for an appeal of that decision if Medicare does not pay.**

- If Medicare has covered your hospital stay, it reviews any individual service it does not cover during that stay, only after you file a claim.
- **If you appeal and Medicare decides to pay despite our opinion, any charges we collected will be refunded to you.**
- **You can ask your physician among others to represent you in filing an appeal.**

**Your Medicare intermediary** does the formal review and makes the payment decision on the service(s) listed on this notice when processing the related claim. If you have questions on that claim or the MSN for the service(s) listed on this notice, you can contact your intermediary. **Your intermediary contact information:**
*(BLANK 5 - INTERMEDIARY NAME, ADDRESS AND TELEPHONE NUMBER)*.

**Quality Improvement Organizations (QIOs)** in each State do certain types of reviews for Medicare, including judging the need for certain medical services and quality of care. You can ask your QIO in your State to review the service(s) listed on this notice after you have received them. **Your QIO contact information:**
*(BLANK 6 - QIO NAME, ADDRESS AND TELEPHONE NUMBER)*.

Sincerely,

*(BLANK 7 - HOSPITAL SIGNATURE)*

**Appendix DE: Model HINN 12 – Non-covered Continued Stay**

*INSERT HOSPITAL LETTERHEAD AND/OR CONTACT INFORMATION*

| | |
|---|---|
| Name of Patient or Representative | Identification Number |

The purpose of this notice is to inform you that we believe your continued hospital stay will not be paid for by Medicare because:

{*Insert Reason Medicare Is Not Expected To Pay*}

Based on our understanding of Medicare policy, we believe that beginning on _____ you will be responsible for payment of your continued stay. **Beginning on this date, you or your other insurance may have to pay for your continued stay. We estimate the cost of your continued stay to be:**

{*Insert Estimated Total or Average Daily Cost}*

**You should talk with your physician about your health care needs, including your continued stay.**

**You can ask us to file a Medicare claim for your continued stay. You will receive a Medicare Summary Notice (MSN) telling you Medicare's payment decision on this claim, and how to ask for an appeal of that decision if Medicare does not pay. If you appeal and Medicare decides to pay despite our opinion, any charges we collected (minus co-pays and deductibles) will be refunded to you.** If you have questions you can call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

This notice is not an official Medicare decision. Your signature below only shows that you have received this notice and understand what you may have to pay for. You will receive a copy of this notice.

| | |
|---|---|
| Signature of Patient or Representative | Date |

**Appendix AS: 240.6 – Documento de prueba 4 – Párrafos modelo de la notificación de no cobertura emitida por el hospital sobre pre-admisión/admisión.**

Identificador del hospital

Notificación de no cobertura emitida por el hospital sobre la pre-admisión o admisión (HINN, por sus siglas en inglés)

Párrafos modelo

Nombre del paciente:_____ Nombre del médico: _____

Número de identificación del paciente:_____ Fecha de emisión:_____

---

Creemos que no es probable que Medicare pague por su admisión para (especifique el servicio o la afección)_____ porque:

_____ no se considera necesaria según la opinión médica

_____ se podría prestar de manera segura en otro entorno

_____ otro _____

Sin embargo, esta notificación no es una decisión oficial de Medicare.

**Si no está de acuerdo con nuestra conclusión:**

- Debe consultar con su médico sobre esta notificación y la atención médica adicional que usted pueda necesitar.
- También tiene derecho a una apelación, es decir, a una revisión inmediata de su caso por una organización para el mejoramiento de la calidad (QIO, por sus siglas en inglés). La QIO es un revisor externo contratado por Medicare para tomar una decisión formal sobre si su admisión está cubierta por Medicare. **Vea la página 2 para obtener instrucciones sobre cómo solicitar una revisión y comunicarse con la QIO.**
- **Si usted decide seguir adelante con la hospitalización, deberá pagar:**

_____[1]

CONTINÚA EN LA PÁGINA 2

[1] Para notificaciones de pre-admisión, inserte: "los gastos habituales por todos los servicios prestados durante la estadía, excepto aquellos servicios a los cuales tiene derecho según la Parte B".

Para notificaciones sobre la admisión emitidas a más tardar a las 3:00 p.m. de la fecha de admisión, inserte: "los gastos habituales por todos los servicios prestados después de la recepción de esta notificación del hospital, excepto aquellos servicios a los cuales tiene derecho según la Parte B". (Si no cumple con estos requisitos, inserte la frase de responsabilidad que se indica a continuación).

Para notificaciones sobre la admisión emitidas después de las 3:00 p.m. del día de la admisión, inserte : "los gastos habituales por todos los servicios prestados durante el día siguiente a la

recepción de esta notificación, excepto aquellos servicios para los cuales reúne los requisitos para recibir el pago según la Parte B".

**Si desea una revisión inmediata de su caso:**

_____ (inserte una de las siguientes, según corresponda)_____

Pre-admisión:

- Llame a la QIO de inmediato al número que aparece a continuación, a más tardar dentro de 3 días calendario después de que reciba esta notificación. Si es admitido, puede llamar a la QIO en cualquier momento durante su estadía.

Admisión:

- Llame a la QIO de inmediato al número que aparece a continuación, o puede llamar a la QIO en cualquier momento durante su estadía.
- También puede llamar a la QIO por asuntos relacionados con la calidad de la atención.

**Información de contacto de la QIO:**_____ (inserte el nombre de la QIO en negritas) _____ (inserte el número de teléfono de la QIO) _____

**Si no desea una revisión inmediata:**

- Aún así podrá solicitar una revisión dentro de los 30 días calendario de la fecha en la que recibió esta notificación llamando a la QIO al número que aparece a continuación.

**Resultados de la revisión de la QIO:**

- La QIO le enviará una decisión formal sobre si su hospitalización es adecuada según las reglas de Medicare, y le informará sobre sus derechos de reconsideración y apelación.
    - SI LA QIO CONCLUYE QUE SU ATENCIÓN HOSPITALARIA ESTÁ CUBIERTA, se le reembolsará todo el dinero que usted le haya pagado al hospital, excepto los copagos, deducibles, artículos de conveniencia o servicios correspondientes que Medicare normalmente no cubre.
    - SI LA QIO CONCLUYE QUE SU ATENCIÓN HOSPITALARIA NO ESTÁ CUBIERTA, usted es responsable del pago de todos los servicios a partir del _____ (especifique la fecha)_____. (ver nota 1 al pie en la página 1).

Para informarse mejor, llame al 1-800-MEDICARE (1-800-633-4227), o TTY: 1-877-486-2048.

---

Firme e inserte la fecha y la hora. Su firma no significa que usted está de acuerdo con esta notificación, sino que usted recibió la notificación y la comprende.

_____ _____ _____

Firma del paciente o representante Fecha Hora

**Appendix BS**: **220.5 – Documento de prueba 3 – Párrafos modelo de notificación de revisión solicitada por el hospital. (Rev.)**

Identificador del hospital

Notificación modelo de revisión solicitada por el hospital (HRR, por sus siglas en inglés)

Nombre del paciente:_____ Nombre del médico: _____

Número de ID del paciente:_____ Fecha de emisión:_____

---

Creemos que Medicare no seguirá cubriendo su atención hospitalaria porque estos servicios ya no se consideran necesarios según la opinión médica en su caso. Como su médico no estuvo de acuerdo con nuestras conclusiones, el hospital solicita que la organización de mejoramiento de la calidad (QIO, por sus siglas en inglés) revise su caso. La QIO es un revisor externo contratado por Medicare para evaluar el caso y decidir si usted está listo para salir del hospital. El nombre de la QIO es _____ **(inserte el nombre de la QIO)**.

- La QIO se pondrá en contacto con usted para solicitar sus opiniones sobre su caso y el cuidado que usted necesita.
- Usted no debe tomar ninguna acción hasta que usted tenga noticias de la QIO.

Para obtener más información sobre esta notificación, llame al 1-800-MEDICARE (1-800-633-4227) o TTY: 1-877-486-2048.

---

Firme, e ingrese la fecha y la hora. Su firma no significa que usted está de acuerdo con esta notificación, sino que recibió la notificación y la comprende.

_____ _____

Firma del paciente o representante: Fecha: Hora

Appendix CS: Carta 11 - HINN Modelo - Servicios no cubiertos durante una estadía cubierta

INSERTE EL MEMBRETE DEL HOSPITAL Y/O LA INFORMACIÓN DE CONTACTO

_____ _____

Nombre del paciente o representante Fecha de notificación

_____ _____

Dirección _____ Fecha de admisión _____

Ciudad, estado, código postal Médico tratante

_____

Número de reclamación del seguro médico (HIC, por sus siglas en inglés)

**SE REQUIERE SU ATENCIÓN INMEDIATA**

El objetivo de esta notificación es informarle que: (Espacio en blanco 1 – Nombre de los servicios) _____ no están cubiertos por Medicare porque: (Espacio en blanco 2 – Motivo de la no cobertura)

_____

_____

_____

Nuestra opinión se basó en la siguiente política de Medicare que nosotros y nuestro intermediario de Medicare seguimos: (Espacio en blanco 3 – Justificación de la evaluación de no cobertura) _____

_____

_____

_____

_____. Si usted decide recibir los servicios indicados anteriormente, según los gastos habituales para estos servicios, usted tendrá la responsabilidad por el pago de: (Espacio en blanco 4 – Responsabilidad financiera del paciente) _____. El médico tratante ha sido informado de nuestra opinión. Usted debería hablar con su médico sobre las necesidades de atención médica, incluso los servicios que se indican anteriormente.

**RECIBO DE ESTA NOTIFICACIÓN**

Esta notificación no es una Decisión oficial de Medicare. Su firma a continuación solo indica que ha recibido la notificación y que comprende lo que debería pagar. En la página siguiente se encuentra la información que deberá emplear si obtiene los servicios y desea averiguar si Medicare está de acuerdo con nuestra opinión. Tenga en cuenta que también le entregaremos una copia de esta notificación a su médico que se indica anteriormente.

_____

Firma del paciente o su representante Fecha

**SU DERECHO A UNA REVISIÓN POR PARTE DE MEDICARE (APELACIÓN):**

Usted puede solicitar que presentemos una reclamación ante Medicare por los servicios que se enumeran en esta notificación. Usted recibirá un Resumen de notificación de Medicare (MSN, por sus siglas en inglés) en la que se expresará la decisión de Medicare respecto del pago por estos servicios, y cómo solicitar una apelación de dicha decisión si Medicare no paga.

- Si Medicare ha cubierto su hospitalización, evalúa todo servicio individual que no cubre durante dicha estadía, únicamente después de que usted presente una reclamación.

- Si usted apela y Medicare decide pagar a pesar de nuestra opinión, todo pago que hayamos recibido se le reembolsará a usted.

- Usted puede solicitar que su médico lo represente en la presentación de la apelación, entre otros.

**Su intermediario de Medicare** hace la revisión formal y toma la decisión sobre el pago respecto de los servicios que se enumeran en esta notificación cuando procesa la reclamación relacionada. Si tiene preguntas sobre dicha reclamación o sobre la MSN correspondientes a los servicios que se enumeran en esta notificación, puede comunicarse con su intermediario. **Información de contacto de su intermediario:** (Espacio en blanco 5 – nombre, dirección, y número de teléfono del Intermediario)

_____

_____

_____

**Las Organizaciones para el mejoramiento de la calidad (QIO)** en cada estado llevan a cabo ciertos tipos de revisiones en nombre de Medicare, incluso determinar de la necesidad de ciertos servicios médicos y la calidad de la atención. Puede solicitar que la QIO en su estado examine los servicios que se enumeran en esta notificación después de que los haya recibido. **La información de contacto del QIO:** (Espacio en blanco 6 – Nombre, dirección, y número de teléfono del QIO)

_____

_____

_____

Atentamente,

(Espacio en blanco 7 - Firma del Hospital)

_____

***Appendix DS:*** *HINN Modelo 12 - Estadía prolongada no cubierta*

INSERTE EL MEMBRETE DEL HOSPITAL Y/O LA INFORMACIÓN DE CONTACTO

_____ _____

Nombre del paciente o del representante Número de identificación

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El objetivo de esta notificación es informarle que creemos que Medicare no pagará por su estadía prolongada en el hospital porque:

{Inserte el motivo por el que no se espera que Medicare pague}

De conformidad con nuestra interpretación de la política de Medicare, creemos que a partir de _____ usted será responsable del pago de su estadía prolongada. **A partir de esa fecha, es posible que usted o su otro seguro deberán pagar por su estadía prolongada. Estimamos que el costo de su estadía prolongada es:**

{Inserte el total estimado o costo promedio diario}

**Usted debe consultar con su médico sobre sus necesidades de atención médica y su estadía prolongada.**

**Puede solicitar que nosotros presentemos ante Medicare una reclamación por sus beneficios de estadía prolongada. Usted recibirá una Notificación resumida de Medicare (MSN) con la decisión de Medicare respecto del pago de dicha reclamación, y cómo solicitar una apelación de dicha decisión si Medicare no paga. Si usted apela y Medicare decide pagar a pesar de nuestra opinión, se le reembolsarán todos los gastos que hayamos recibido (menos los co-pagos y deducibles).** Si tiene preguntas puede llamar al **1-800-MEDICARE** (**1-800-633-4227/TTY**: 1-877-486-2048).

Esta notificación no es una Decisión oficial de Medicare. Su firma a continuación solo indica que ha recibido esta notificación y que comprende lo que debería pagar. Usted recibirá una copia de esta notificación.

_____ _____

Firma del beneficiario o del representante Fecha