ADVANTAGE
Sleep Centers

Please complete this form if Medicare is your Primary Insurance Carrier

Notice of Medicare Provider Non-Coverage

Patient Name: _____ Medicare Number: _____
THE EFFECTIVE DATE OF YOUR CURRENT COVERAGE WILL END: _____.

- Your provider has determined that Medicare probably will not pay for your _____ services after the effective date listed above.
- You may have to pay for any of the _____ services you receive after the above date.

YOUR RIGHT TO APPEAL THIS DECISION

- You have the right to an immediate, independent medical review (appeal), while your services continue, of the decision to end Medicare coverage of these services.

- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer will also 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 notice 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 that service should no longer be covered after the effective date indicated above, Medicare will not 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 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 will notify you of it's decision as soon as possible, generally by no later than two days after the effective date of this notice.

- To call your QIO to appeal or if you have any questions: Call PRONJ, The Healthcare Quality Improvement Organization, Inc. at 1-800-624-4557.

OTHER INFORMATION:
Contact 1-800-MEDICARE (1-800-633-4227), or TTY/TDD (1-877-486-2048) for more information about the appeals process

Please sign below to indicate you have received 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 Authorized Representative Date

Form No. CMS-10123 Exp. Date xx/xx/xxxx

ADVANTAGE
Sleep Centers

Please complete this form if you have Medicare as your Primary Insurance Carrier

Medicare Primary Payer Questionnaire

The questions listed below are for beneficiaries or older, and is used to comply with Medicare Regulations 42 CFR 489.20 (F)

1. Are you currently working full or part time? Yes No

2. If married, is your spouse working full or part time? Yes No

3. Are you currently under any employer group health plan? Yes No
   If yes, please provide the following information:
   Name of Insured: _____
   Relationship to Patient: _____
   Name of Employer: _____
   Name of Insurance Carrier: _____
   Group/Policy#: _____

4. Are you entitled to Black Lung Benefits? Yes No

5. Is the service for treatment work related? Yes No

6. Is this service for treatment related to an auto injury? Yes No

7. Are benefits for services being submitted to any other party for reimbursement consideration? Yes No

Patient Name _____ Date _____

Patient Signature _____