

## HANDOUT 13

### **240.6 – Exhibit 4 – Model Language for Preadmission/Admission Hospital Issued Notice of Noncoverage.**

Hospital Identifier

Preadmission or Admission Hospital-Issued Notice of Noncoverage (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:**

\_\_\_\_\_ <sup>1</sup>

CONTINUED ON PAGE 2

<sup>1</sup> 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."

## HANDOUT 13

### ***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 footnote<sup>1</sup> 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

# HANDOUT 13

## Model HINN 12 - Noncovered 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 Beneficiary or Representative

---

Date