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