Form Instructions for the Notice of Denial of Medical Coverage
CMS-10003-NDMC

A Medicare health plan ("plan") is to complete and issue this notice when it denies a request for medical service, in whole or in part. This is not model language. This is a standard form. Plans may not deviate from the content of the form provided. Please note that the OMB control number must be displayed on the notice.

Heading

- **Date~~.--~~:__Enter the month, day, and year ~~that~~ the notice is being issued.**

- **__Beneficiary's ~~Name.--~~name:__Enter the full name of the enrollee.**

- **__Member ~~Number.--~~number:__ Enter the enrollee's ~~M~~medical or other ~~I~~Didentification number. (HIC n~~N~~umber ~~may~~ must not be used~~.~~.)**
- **__We have denied coverage of the following medical services or items requested~~.--~~:__List the denied medical services or items.**
- **We denied this request because~~.--~~:__The plan must provide a specific and detailed explanation of why the medical services or items are being denied, with the description of any applicable Medicare coverage rule or any other applicable plan policy upon which the denial decision was based.**

Section Titled: What If I Don't Agree With This Decision?

No information is required to be completed.

Section Titled: Who May File An Appeal?

In the spaces provided, the plan is required to enter the plan's telephone and TTY ~~number(s)~~numbers where the enrollee can learn how to name a representative.

Section Titled: There Are Two Kinds of Appeals You Can File

No information is required to be completed.

Section Titled: What Do I Include With My Appeal?

No information is required to be completed.

Section Titled: How Do I File An Appeal?

Under the subsection "For a Standard Appeal~~" --- The~~", the plan must provide the address where the enrollee, physician or representative can mail or hand deliver a standard appeal.

Under the subsection "For a Fast Appeal", ~~--T~~the plan is required to enter the telephone, TTY, or fax ~~number(s)~~numbers where the enrollee, physician or representative can request an expedited (fast) appeal.

Section Titled: What Happens Next?

No information is required to be completed.

Section Titled: Contact Information

In the spaces provided, the plan is required to enter the plan's telephone and TTY ~~number(s)~~numbers for the enrollee, physician or representative to call if they need information or help.

Section Titled: Other Resources to Help You

~~No information is required to be completed.~~ **~~[PLACEHOLDER FOR NEW DISCLOSURE STATEMENT + NOTICE EXPIRATION DATE]~~**.

~~OMB Approval 0938-0829~~

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0829**. The time required to complete this information collection is estimated to average **10 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attention: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.