[INSERT PROVIDER CONTACT INFORMATION HERE]

<Date>

<Facility Name>

<Facility Address>

<Facility City/State/Zip>

ATTN: Utilization Department

<Name/Contact Info for UM Department/Director>

RE: Denial of Coverage for Inpatient Hospitalization

<Tracking or Authorization #>

Member: <Member’s Name>

DOB: <DOB>

Member ID: <Member ID #>

This letter is to inform <insert name of facility> that the hospitalization referenced below has been reviewed by <the Physician Reviewer at Provider Organization, Medical Director’s Name>:

The <Insert LOC> hospital days <insert denied dates> at <Name of Facility> have been denied.

Based on review of the available medical record and clinical information, <the Provider Organization> has determined that the hospital days referenced above are denied for the following reason(s):

[ ]  Clinical information requested <Insert dates clinical was requested> was not received

[ ]  Administrative Hospital Delay (Ordering/arranging for diagnostic testing/treatments/therapies, including physical therapy, consultation/surgical-other procedures or test results that will likely result in a longer length of stay than if care were provided/arranged efficiently)

[ ]  Did not meet <Enter name of your criteria used> criteria for Admission

<Specify criteria or medical necessity not met--indicate at what level of care more appropriate>

[ ]  Did not meet <Enter name of your criteria used> criteria for Continued Stay

<Specify criteria or medical necessity not met--indicate at what level of care more appropriate>

[ ]  Other: <Describe>

[ ]  Additional comments: <Specify information not received, or more information about specific reasons for denial>

If <Insert Name of Facility> is aware of relevant information which may affect this determination, please contact your UM representative <Insert Provider Group contact name and #> within one business day of receipt of this notice.

**Please note that the member or patient may not be billed for these services under the terms of your SCAN Plan Provider Agreement AND/OR your contract with Medicare.\***

Medicare Managed Care Manual Ch. 4 Section 170.1 excerpted, Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full.

Sincerely,

<Insert Medical Director Contact Information at Provider Organization>

***\*****Balance billing Medicare members for Medicare covered services is expressly prohibited. All entities balance billing SCAN members will be reported to the SCAN Special Investigation Unit for appropriate Fraud, Waste, and Abuse examination, assessment, and action.*