**[LOGO]**

**Notice of Reinstatement of Coverage**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­**

**Date: \_\_\_\_\_\_\_\_\_\_\_ Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider/Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Service Start/Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Attending Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Type of Service:**

**Skilled Nursing**

**Home Health**

**Comprehensive Outpatient Rehabilitation**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dear [insert: Member's Name]:**

On [insert: date] you received a Notice of Medicare Non-Coverage indicating the above services would end effective [insert: date] and that you would have to pay for any services you receive after that date.

This Reinstatement Notice is to inform you that upon further review, it has been determined that the above services shall continue with no lapse in coverage until further notice.

You will receive a new Notice of Medicare Non-Coverage indicating when your coverage will end, when it has been determined that you no longer require the above services.

If you have any questions regarding this Reinstatement Notice, please contact [insert organization name: PMG/IPA] at [XXX-XXX-XXXX] or TTY/TDD at [XXX-XXX-XXXX] [insert: days of operation] between the hours of [insert: hours].

Sincerely,

[Provider Organization Designee]