

Notice of Non-Coverage

Patient Name: _____ **Ins. ID:** _____

Insurance Company: _____

Facility Name: _____

Your insurance company has communicated to us that your inpatient services are no longer covered for the following reasons:

- _____ Benefits exhausted
- _____ Care no longer meets coverage criteria as determined by your Insurance Company
- _____ You and the facility staff have determined you are ready for discharge from inpatient skilled services.
- _____ Other: (specify)

The last covered day for insurance inpatient payment is _____.
The date for discharge from skilled care is _____.

If you disagree with the above determination, please contact the customer service for your Insurance Company to obtain the process for appeal. The number for customer service is located on your insurance card. Please stop by our business office to discuss co-payments, deductibles and coinsurance payments prior to your discharge.

Please sign below to indicate that you have received this notice.

I have been notified that coverage of my skilled care services will end on the last covered day indicated on this notice and that I may appeal this decision following the direction of my insurance company.

Signature of Patient or Authorized Representative

Date

Witness

Date

Please file in resident's chart