Optional Form to Document Alternate Delivery

Please fax completed (signed) Notice of Medicare Non-Coverage (NOMNC) to: _____

CONFIRMATION OF NOTICE BY TELEPHONE

(Notification by telephone is done only in situations where the notice must be delivered to an enrollee in an institutional setting, who is unable to make decisions for him/herself. See Medicare Managed Care Manual, Chapter 13, Section 60.1.3 for reference.)

Name of person contacted: _____

Date of contact: _____ Time: Telephone Number called: ____ ☐AM ☐PM

_____ _____

Signature of Health Plan/SNF/HHA/CORF/Medical Group Representative Date

CONFIRMATION OF FOLLOW-UP NOTICE BY MAIL

(Notification by mail must also be done if telephone notification was made. This is done only in situations where the notice must be delivered to an enrollee in an institutional setting, who is unable to make decisions for him/herself. See Medicare Managed Care Manual, Chapter 13, Section 60.1.3 for reference.)

Mailing address: _____

_____

_____

Date sent: Via: ☐ US Mail ☐ Certified Mail ☐ FedEx ☐ Priority Mail

Tracking # (if applicable): _____

CONFIRMATION OF REFUSAL TO SIGN

I confirm that the Notice of Medicare Non-Coverage was hand-delivered to the member or the member's authorized representative; however, the member or the member's authorized representative refused to sign the acknowledgment of receipt.

Name of person receiving notice:

Date of delivery: Time: ☐AM ☐PM

_____ _____

Signature of Person Delivering Notice Date

_____ _____

Signature of Witness to Delivery of Notice Date

Guidance Checklist When Issuing NOMNC to Other Than Member (See Medicare Managed Care Manual, Chapter 13, Section 60.1.3)	Responsible Party		Initial Completed	Date	Time
	SNF	*MG/IPA*			
Call patient's representative the day notice is issued. (Date of conversation is the date of the receipt of the NONMC). ID self and give organization, contact name and number, purpose of call (right to file an appeal) and describe the appeal right being discussed (e.g. QIO vs expedited).					
Inform representative that skilled services will no longer be covered beginning on: (date) _____ and financial responsibility starts on (date) _____.					
Advise representative of appeal rights. (You must read directly from the letter.)					
Advise representative that an appeal must be phoned to Livanta by 12:00 pm the following day of receipt of the NOMNC or phone call.					
Provide the representative with the QIO name (Livanta) and phone number listed in the appeal section of the letter. Provide address, fax or other method of communication needed by representative for QIO to receive appeal in a timely fashion.					
Inform representative how to get a detailed notice describing why the enrollee's services are not being covered.					
Provide at least one phone number of an advocacy organization or 1-800-MEDICARE.					
Confirm the telephone contact by written notice mailed same day.					
If direct phone contact cannot be made, including leaving voice mail, mail the notice to the representative, certified mail, return receipt requested. (If the **Medical Group** is sending the certified mail, the Facility must notify the Medical Group immediately that certified mail is required.) (If the **Facility** sent the certified mail, and Livanta is processing an appeal, the certified returned receipt must be submitted to Livanta. If not submitted, the appeal may be decided in favor of the member solely due to lack of the receipt which is the evidence of timely notification.)					
Document that representative verbalizes understanding of the information provided.					