

Notice of Medicare Non-Coverage

Patient name:

Patient number:

The Effective Date Coverage of Your Current _____
Services Will End: _____

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- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
 - You may have to pay for any services you receive after the above date.
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Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
 - If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
 - If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
 - If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
 - Neither Medicare nor your plan will pay for these services after that date.
 - If you stop services no later than the effective date indicated above, you will avoid financial liability.
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How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO **Livanta** at: 787-520-5743

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048 for more information about the appeals process.

Plan Contact Information:

Triple-S Advantage
Toll Free Number 1-888-620-1919
TTY/TDD 1-866-620-2520
Mobile 787-421-5134 (weekends and holidays)

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative

Date

**NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND
ACCESSIBILITY REQUIREMENTS AND NONDISCRIMINATION STATEMENT:
DISCRIMINATION IS AGAINST THE LAW**

Triple-S Advantage, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Triple-S Advantage, Inc. does not exclude people or treat them differently because of race, color national origin, age, disability, or sex.

Triple-S Advantage, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not Spanish, such as:
 - Qualified interpreters
 - Information written in other languages.

If you need these services, contact a Service Representative.

If you believe that Triple-S Advantage, Inc. has failed to provide these services or discriminated in another way on the basis of race, color national origin, age, disability, or sex, you can file a grievance with:

Service Representative
P.O Box 11320, San Juan, PR
00922-1320
Telephone: 1-888-620-1919, TTY: 1-866-620-2520
Fax. 787-993.3261, e-mail: TSACompliance@sssadvantage.com

You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, a Service Representative is available to help you.

You can also file a civil rights complaint with the US Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-620-1919 (TTY: 1-866-620-2520).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-620-1919 (TTY: 1-866-620-2520)。

ATENCIÓN: si usted habla español, servicios de asistencia lingüística están disponibles libre de cargo para usted. Llame al: 1-888-620-1919 (TTY: 1-866-620-2520).