WellSense Medicare Plan

NOMNC Form and Instructions

Below is a copy of the WellSense Member NOMNC for providers to utilize for administering to any WellSense Medicare patient whose Home Care, CORF, Hospice or Skilled Nursing will be ending.

This notice must be delivered and signed at least two days prior to their discharge day.

Please have member or their representative sign and date the attached form.

Once NOMNC has been delivered please send signed copy to WellSense to:

WellSense UM Department

Fax #: 866-336-2445

**Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents*

WellSense Health Plan, 855-833-8125 (TTY: 711)
Notice of Medicare Non-Coverage

Patient name: ___________________ Patient number: ___________________

The Effective Date Coverage of Your Current [__________________________] Services Will End: [__________]

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current ____ services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

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.

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 at: ACENTRA toll free 888-319-8452 TTY 855-843-4776 24 hours per day, 7 days per week to appeal, or if you have questions.

See page 2 of this notice for more information.

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:

  WellSense Health Plan
  Toll Free: 855-833-8125 (TTY: 711)
  Monday through Friday 8 a.m. to 8 p.m., Eastern Standard Time. (Representatives are available 7 days a week, 8 a.m.-8 p.m., Eastern Time from Oct. 1-Mar. 31)

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