Date: [Insert Date]

Patient Name: [Insert Patient Name]
Medicare Number: [Insert Medicare Number]

Notice of Medicare Non-Coverage / Financial Responsibility

Dear [Patient Name],

This notice is to inform you that Medicare is not expected to pay for the following services/items starting on **[Insert Date]**:

Description of Services/Items:
[Insert description of specific services, procedures, or equipment]

Reason for Non-Coverage:
[Insert specific reason, e.g., Not medically necessary, Frequency limit reached, Maintenance care only]

Estimated Cost: $[Insert Estimated Amount]

Because we do not expect Medicare to pay for the services listed above, you will be financially responsible for the full cost of these services if you choose to receive them. This notice serves as your formal notification of potential financial liability.

Your Options:

- **Option 1:** You want the services/items listed above. You agree to pay for them out-of-pocket if Medicare does not pay.
- **Option 2:** You do not want the services/items listed above and will not be charged.

Signature:

By signing below, you acknowledge that you have received this notice and understand that you are responsible for the costs if Medicare denies payment.

_____
Patient or Representative Signature

_____
Date

Provider Information:
[Insert Facility/Provider Name]
[Insert Address]
[Insert Phone Number]