

[Facility/Provider Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

Patient Name: [Patient Name]
Medicare Number: [Medicare Number]
Date(s) of Service: [Service Dates]

Notice of Medicare Denial of Payment

Dear [Patient Name],

This letter is to inform you that we have received notification that Medicare will not pay for the following services/items provided to you on the dates listed above:

Description of Service/Item: [Specific Service or Item Name]

Reason for Denial:

[Insert reason, e.g., Not medically necessary, Care exceeds limit, Non-covered benefit, etc.]

Financial Responsibility:

Because Medicare has denied payment for these services, you are now responsible for the remaining balance of \$[Amount]. Our records indicate that you previously signed an Advance Beneficiary Notice of Non-coverage (ABN) on [Date of ABN signing], acknowledging that you would be responsible for payment if Medicare denied the claim.

How to Appeal:

You have the right to appeal this decision. To start an appeal, follow the instructions provided on your Medicare Summary Notice (MSN). You may also contact 1-800-MEDICARE (1-800-633-4227) for assistance with the appeals process.

Payment Instructions:

Please remit payment by [Due Date]. If you have already made a payment or have secondary insurance that may cover this balance, please contact our billing office at [Phone Number] immediately.

Sincerely,

[Name of Billing Manager/Representative]
[Facility/Provider Name]