Facility name:_____ **Provider #:_____**

Individual completing form:_____ **Date of completion:_____**

Medicare Review

1. Please identify residents who have requested a demand bill in the last 6 months.

_____

_____

_____

2. Please identify six residents that have been discharged from Medicare Part A skilled services (all skilled services terminated before the resident exhausted their 100 day benefit). **Please note whether the resident remained in the facility after Part A benefits terminated.**

1. _____

2._____

3. _____

4._____

5._____

6._____

PLEASE RETURN TO THE SURVEY TEAM PRIOR TO COMPLETING SIDE 2

Medicare Review

Listed below are the names of the residents I have selected for the task of Medicare Review - Liability Notices and Beneficiary Appeal Rights. **For each resident listed below:**

- Please provide me with **Denial Notices/Letters** *or* **SNFABNs** (with the right to demand bill); *and* any **Notices of Medicare Provider Non-Coverage** for the last 6-9 months.

- If a demand bill was requested, then please provide evidence of submission of the claim to Medicare (or explain the reason why the claim has not been submitted yet).

- Please identify in writing, behind each resident name, any service(s) under Medicare Part A the resident received (i.e., PT, OT, etc.), and the date(s) when the service(s) was terminated (i.e. Mary Smith – received the service of PT & OT under Medicare Part A – OT terminated on 02/24/09 & PT terminated on 03/03/09).

- If **Denial Notices/Letters** *or* **SNFABNs**; *and* **Notices of Medicare Provider Non-Coverage** were not given in the last 6-9 months; please identify in writing, behind each resident name, the reason these notices were not given.

1. _____
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3. _____
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4. _____
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