CarePartners of Connecticut
MEDICARE ADVANTAGE

[Date]

[Facility Name]
[Address]

Member Name: [Member Name]
Member ID#: [Member ID#]
Case #: [Reference #]

Dear *[Name of Member or Authorized Representative]:*

On *[Date of NOMNC Notice]*, you received notice that your *[Skilled Nursing Facility / Acute Rehabilitation / Long Term Acute Care]* services did not meet Medicare coverage guidelines beginning *[Last Date Plus One]*. This letter is to notify you that on *[Date of Reinstatement]*, it was determined the *[Skilled Nursing Facility / Acute Rehabilitation / Long Term Acute Care]* you are/were receiving are/were medically necessary and coverage for these services has been reinstated by CarePartners of Connecticut.

Medicare covers medically necessary *[Skilled Nursing Facility / Acute Rehabilitation / Long Term Acute Care]* services. Therefore, you are not responsible for payment of these services received from *[Facility Name]* from the following date *[From Date]* through *[To Date]*. You may be liable for member cost share, based on your CarePartners of Connecticut Evidence of Coverage.

If you previously paid for these services and require assistance with obtaining reimbursement or should you have any further questions regarding this letter, please contact CarePartners of Connecticut Member Services at 1-888-341-1507 (HMO) or 1-866-632-0060 (PPO) (TTY: 711) for more information. Representatives are available Monday-Friday 8:00am-8:00pm (Representatives are available 7 days a week, 8:00am-8:00pm from October 1-March 31).

After hours and on holidays, please leave a message and a representative will return your call on the next business day.

Sincerely,

CarePartners of Connecticut

cc: *[PCP Name]*
[Member Name]