

Detailed Notice of Discharge

| Date: | _ |
|--|---|
| Patient Name: | _ Patient Number: |
| This notice gives a detailed explanation of why your hospital or M your hospital stay should end. This notice is not the decision on y your Quality Improvement Organization (QIO). | |
| We have reviewed your case and decided that Medicare coverage | e of your hospital stay should end. |
| The facts used to make this decision: | |
| | |
| | |
| Detailed explanation of why your hospital stay is no longer cover used to make this decision: | ered, and the specific Medicare coverage rules and policy |
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| | |
| • Plan policy, provision, or rationale used in making the decision (| health plans only): |
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| | |
| If you would like a copy of the policy or coverage guidelines used the QIO, please call us at: | to make this decision, or a copy of the documents sent to |
| You have the right to get Medicate information in an accessible formatile a complaint if you feel you've been discriminated against. Visit Medicall 1-800-MEDICARE (1-800-633-4227) for more information. TTY us | edicare.gov/about-us/accessibility-nondiscrimination-notice, or |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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