

**McLaren Print System Order**

**Order No: 74504**  
**Order Date: 2023-01-09**  
**User: Raynette K. Gaines**  
**Phone: 586-493-8010**

**Ship Location: McLaren Oakland Hospital**  
**50 North Perry St**  
**Pontiac , MI 48342**

**Forms**  
**Quantity: 1000**  
**Paragon Dept No: 12300-1175**  
**Dept Name: Case Management**  
**Company Number: 310**

**Order Total Price: 264.00**

**Item Number: CMS-10065-IM (Oakland)**  
**Item Description: Important Message from Medicare**  
**Revision Date: 4/2020**  
**Print: 2 sided black and white**  
**Paper: 2 Part (White, Yellow)**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish: None**  
**Drill: None**  
**Poster:**  
**Misc Info: ds; 2 part; black**

**How to Ask For an Appeal of your Hospital Discharge**

- You must make your request to the QIO listed above.
- Your request for an appeal should be made as soon as possible, but no later than your planned discharge date and before you leave the hospital.
- The QIO will notify you of its decision as soon as possible, generally no later than 1 day after it receives all necessary information.
- Call the QIO listed on Page 1 to appeal, or if you have questions.

**If You Miss The Deadline to Request An Appeal, You May Have Other Appeal Rights:**

- If you have Original Medicare: Call the QIO listed on Page 1.
- If you belong to a Medicare health plan: Call your plan at:

Medicare Plus Blue 1-877-241-2583	HAP Senior Plan 1-800-801-1770
Blue Care Network 1-800-450-3680	Humana Advantage 1-800-457-4708
Molina Advantage 1-800-665-3072	Priority Advantage 1-888-389-6648
McLaren Health Plan 1-888-327-0671	

For more information, call 1-888-MEDICARE (1-888-633-4227), or TTY: 1-877-496-2648. CHS does not discriminate in its programs and activities. To request this publication in an alternate format, please call 1-888-MEDICARE or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).

**Additional Information (Optional):**

Please sign below to indicate you received and understood this notice.

I have been notified of my rights as a hospital inpatient and that I may appeal my discharge by contacting my QIO.

Signature of Patient or Representative

Date / Time

**Spec Info: Please deliver to Case Management on 1st floor west tower. Please contact Raye, CM Tech at 586 255-4165 with any questions.**

(If Certified Mail Number)

Date / Time

According to the Freedom of Information Act (FOIA), we provide you request to inspect or copy certain records. The cost of such records under the information collection is \$0.00. The data required to complete this information collection is submitted in a secure manner. We do not collect, use, disclose, or disseminate this information for any other purpose. If you have any questions regarding the accuracy of the information or require further information regarding this notice, please contact the OIG, 500 Maryland Drive, Suite 3000, Bethesda, Maryland 20814.

Form area with checkboxes and lines for signature and date.