

McLaren Print System Order

Order No: 77335 Reprint Previous Order No: 53397
Order Date: 2023-05-17
User: shelby brandon
Phone: 810-342-2362

Ship Location: McLaren Flint - 1 North Physical Therapy Attn: Shelby Brandon
401 S. Ballenger Hwy
Flint, MI 48532

Forms

Quantity: 500
Paragon Dept No: 27410
Dept Name: McLaren Flint Rehab Unit 4 North
Company Number: 60

Order Total Price: 139.60

Item Number: CMS-10065-IM (Flint)
Item Description: Important Message from Medicare
Revision Date: 03/2023
Print: 2 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info: ds; 2 part; black



1-810-342-2000 or 1-800-621-6517

Important Message from Medicare

Your Rights as a Hospital Inpatient

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
You can be involved in any decisions about your hospital stay.
You can report any concerns you have about the quality of care you receive to your QIO.
You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital.
You can speak with your doctor or other hospital staff if you have concerns about being discharged.

Additional Information (Optional):

Is there any needed documentation to add?

Per instructions: Additional information (Optional): This section provides space for additional pertinent information that may be useful to the beneficiary/employee. It may not be used as a Detailed Notice of Discharge, even if facts pertinent to the termination decision are provided.

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/representative: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Unable to sign Patient representative notified: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Patient refused to sign Hospital Rep: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Certified Mail Number: \_\_\_\_\_

2nd IMM Discharge Staff: \_\_\_\_\_ Date/Time: \_\_\_\_\_

According to the Payment Reduction Act of 2012, we provide an appeal to request a review of administrative action in English or Spanish. For more information, please call 1-800-621-6517. The new appeal to request the administrative action is required to be made within 60 days of the date of the administrative action. For more information, please call 1-800-621-6517. If you have concerns regarding the accuracy of the information on this form, please call 1-800-621-6517. If you have concerns regarding the accuracy of the information on this form, please call 1-800-621-6517. If you have concerns regarding the accuracy of the information on this form, please call 1-800-621-6517.

See page 2 of this notice for more information.

OMB approved 0930-1019

Form CMS-10065-IM Rev. 10/01/2020

Form with fields for initials and dates.