MEDICARE STATUS NOTICE

To: Business Office / Medical Records
From: Director of Nursing Services
Date: _____

Please be advised of the following Status Change:

Resident Name: _____

☐ **Medicare Denial**

A. Denial Date: _____

B. Type of Denial Letter

- ☐ Intermediary Determination of Non-Coverage
- ☐ UR Committee Determination of Admission
- ☐ UR Committee Determination on Continued Stay
- ☐ SNF Determination on Admission
- ☐ SNF Determination on Continued Stay

C. Denial Paragraph Number _____

D. First Day of Non-Coverage: _____ Financial Class: _____

E. Notice of Transfer _____

F. Room Change: From _____ To _____ Date _____

☐ **Reinstated to Medicare**

A. First Day of Coverage: _____

B. Notice of Transfer _____

C. Room Change: From _____ To _____ Date _____