[HEALTH PLAN OR MEDICAL GROUP/IPA LETTERHEAD]
(Use 12-point font)
COMMERCIAL
REINSTATEMENT NOTICE FOR
SKILLED NURSING FACILITY - CONTINUED STAY
(*Issue if skilled level of care is reinstated*)

[*Date*]

[*Name of Member or Member's representative*]
[*Address*]
[*City, State, ZIP*]

Member Name:
DOB:
Member ID#:
Health Plan Name:
Facility Name:
Admission Date:
Date Service Initiated or Requested:
Attending Provider/Physician:

Dear [*Member Name*]:

On [*insert date*] you received notice that [*insert health plan or medical group/IPA name*] determined that your [*insert one:* admission ***or*** continued stay] did not meet your Health Plan's coverage guidelines for skilled nursing facility care. This determination was based upon our review of your medical condition in relation to your Health Plan's coverage guidelines for skilled nursing facility care.

This letter is to notify you that effective [*insert: reinstatement date*] due to the change in your clinical condition your stay in the skilled nursing facility now meets your Health Plan coverage guidelines and is therefore covered. [***insert as applicable:*** You remain responsible for payment of services provided to you from [(*date*) to (*date*)].

If you have any question regarding this notice or your financial liability for denied charges, please contact [*insert one: Health Plan or Medical Group/IPA name* at ***X-XXX-XXX-XXXX*** or TTY/TDD at ***X-XXX-XXX-XXXX***].

Sincerely,

_____
Medical Director (Designee)
[*Name of health plan or medical group/IPA*]

C. Member File
Requesting Physician
PCP
SNF Business Office