## Form Instructions for the Important Message from Medicare
**(IM) CMS-10065**

**Page 1 of the Important Message from Medicare (IM)**

Patient name: Fill in the patient's full name or attach patient label.

Patient ID number: The Patient number may be a unique medical record or other provider-issued identification number. It may not be the Social Security Number, Health Insurance Claim Number (HICN) or any other Medicare-issued identifier for the beneficiary such as the MBI (Medicare Beneficiary Identifier).

Hospital name: Insert hospital or Medicare health plan name here.

Hospital address: Insert hospital or Medicare health plan address here.

Hospital telephone number: Insert hospital or Medicare health plan telephone number here.

~~**Heading:** Insert contact information here: The name, address and telephone number of the hospital or Medicare health plan that delivers the notice must appear above the title of the form. The entity's registered logo is not required, but may be used.~~

~~**Patient Name:** Fill in the beneficiary's/enrollee's first and last name.~~

~~**Patient number:** The Patient number may be a unique medical record or other provider issued identification number. It may not be the Social Security Number, HICN or any other Medicare number issued to the beneficiary such as the MBI (Medicare Beneficiary Identifier).~~

**Bullets 3 & 5:** Insert the name and toll-free number of the Quality Improvement Organization (QIO) for the state in which the hospital is located.

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~~**Bullet 4:** Insert the name and toll-free number of the QIO for the state in which the hospital is located.~~

**Bullet 8 (plans only):** The plan's name and contact information must be displayed here for the enrollee's use in case an expedited appeal is requested or in the event the enrollee or QIO seeks the plan's identification.

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

**Signature line:** Have the beneficiary/enrollee or representative sign the notice to indicate that he or she has received it and understands its contents.

**Date/Time:** Have the beneficiary/enrollee or representative write the date and time that he or she signed the notice. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, annotate the IM to indicate the date and time that the notice was delivered.

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 15 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.