

Sample Letter to Beneficiary from Supplier that Chooses to Grandfather

Our records show that our company, **[insert supplier name]**, is currently furnishing you with rented **[insert name of equipment]**.

On January 1, 2011, Medicare started a new Competitive Bidding Program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in your area. The current competitive bidding program supplier contracts in your area will end on December 31, 2016. On January 1, 2017, Medicare will start new contracts with suppliers in your area. Under this program, people with Original Medicare in your area will almost always need to buy or rent certain medical equipment and supplies from suppliers that contract directly with Medicare to furnish these items. Although we won't be a Medicare contract supplier for your equipment starting January 1, 2017, we qualify as a grandfathered supplier so you may continue to rent your equipment from us. This also includes getting related accessories and supplies needed to operate the equipment for the remaining rental months.

It is important for you to know that you may change suppliers. However, if you change suppliers, you must get your **[insert name of equipment]** from a new Medicare contract supplier for your area. To find a Medicare contract supplier for **[insert name of equipment]**, visit www.medicare.gov/supplier or call 1-800-MEDICARE (1-800-633-4227) and have your ZIP code ready. TTY users should call 1-877-486-2048.

If you choose to use a new Medicare contract supplier instead of continuing to rent with us, the contract supplier must provide you with the items included in its contract. *[USE FOLLOWING SENTENCE FOR RENTED DURABLE MEDICAL EQUIPMENT EXCEPT OXYGEN AND OXYGEN EQUIPMENT:]* The Medicare contract supplier will receive 13 additional months of rental payment for medical equipment. *[USE FOLLOWING SENTENCE FOR OXYGEN AND OXYGEN EQUIPMENT:]* The Medicare contract supplier will receive at least 10 months of rental payment for oxygen equipment. You or your secondary insurer will be responsible for the 20 percent copayment for the monthly rental and any unmet Part B annual deductible. If you continue to rent with us, you will be responsible for **[insert # of months]** of monthly rental copayments and any unmet Part B annual deductible.

Please respond by checking the appropriate box below and mailing it to **[insert supplier address]** or you may call us at **[insert supplier phone number]** to let us know if you would like to continue to rent from us or switch to a contract supplier. Please respond by **[insert date]**. If you choose to switch to a contract supplier, we will contact you to arrange a convenient time to pick up your equipment.

If you have any questions, please call us at **[insert supplier phone number]** or call 1-800-MEDICARE (1-800-633-4227).

Customer Name (please print) _____ has decided to:

- ☐ continue renting **[insert name of equipment]** from **[insert supplier name]**
☐ **NOT** to continue renting **[insert name of equipment]** from **[insert supplier name]**

Signature _____ Date _____