

**PART D QIC LATE ENROLLMENT PENALTY (LEP) RECONSIDERATION  
CASE FILE TRANSMITTAL FORM**

Name of Part D Plan: \_\_\_\_\_

Date on LEP Notice to Enrollee (Chapter 4, Exhibit 3): \_\_\_\_\_

<b>Appellant Name</b>	<b>Enrollee Name</b>

<b>Enrollee HIC/Medicare Claim Number</b>	<b>Date of Birth</b>

**Enrollee Address and Phone Number:**

**Part D Plan Information:**

Plan Type:    PDP (S#)    MA-PD (H or R#)    Cost    Employer Sponsored (E#)

Plan Contract# (H/S/R/E) \_\_\_\_\_ (Circle H S R or E and list the 4 digit CMS Plan Contract #)

Plan ID # \_\_\_\_\_

Plan Contact (Name/Title) \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

Plan Address \_\_\_\_\_

\_\_\_\_\_

**For Enrollees with a Representative for this LEP Reconsideration Request:**

Name of Representative \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_



**Plan Level LEP Information:**

**LEP Determination:**

Enrollee's Entitlement Date to Medicare Part D: \_\_\_\_\_

Enrollee's Part D Initial Enrollment Period (IEP): From \_\_\_\_\_ To \_\_\_\_\_

Date on Beneficiary Attestation of Creditable Prescription Drug Coverage, if applicable (Chapter 4, Exhibit 1): \_\_\_\_\_

Date Beneficiary Attestation of Creditable Prescription Drug Coverage was Received by Plan, if applicable: \_\_\_\_\_

Plan LEP Determination Date: \_\_\_\_\_ CMS LEP Notification Date: \_\_\_\_\_

Enrollee LEP Notification Date: \_\_\_\_\_

LEP Effective Date: \_\_\_\_\_

Part D Plan Premium (including LEP amount): \$ \_\_\_\_\_

CMS Calculated LEP: \$ \_\_\_\_\_

Dates without Creditable Prescription Drug Coverage: From \_\_\_\_\_ To \_\_\_\_\_

(If necessary, list additional dates without creditable coverage on a separate sheet.)

Number of Uncovered Months Reported to CMS: \_\_\_\_\_

**Enrollee Coverage Information:**

**Current Plan Information:**

Name of Part D Plan: \_\_\_\_\_

Part D Enrollment Effective Date \_\_\_\_\_

Is the Enrollee receiving a Low-Income Subsidy (LIS): Yes  No

Amount of Low-Income Subsidy: \$ \_\_\_\_\_

Exhibits: Label applicable exhibits with letters provided below, and place them in order by letter.	
<b>Procedural Documents</b>	<input type="checkbox"/> <b>A.</b> Case Narrative cover page that presents an overview of the appeal: Describe the issue on appeal; identify all relevant information (Optional) <input type="checkbox"/> <b>B.</b> Beneficiary Attestation of Creditable Coverage <input type="checkbox"/> <b>C.</b> Letter Informing Beneficiary of LEP <input type="checkbox"/> <b>D.</b> Representation Documents (AOR or other writing, DPOA/POA, Healthcare Proxy, Surrogate for an incompetent enrollee under State law, estate representative) <input type="checkbox"/> <b>E.</b> Other (describe or list below additional exhibits the Plan considers important) <hr/> <hr/> <hr/> <hr/>
<b>Evidentiary Documents</b>	<input type="checkbox"/> <b>F.</b> Application for Enrollment in Part D Plan <input type="checkbox"/> <b>G.</b> Notice Informing Beneficiary of Part D Enrollment Effective Date <input type="checkbox"/> <b>H.</b> BEQ/MARx Screen verifying enrollee's Part D Entitlement and Part D Plan Enrollment and Creditable Prescription Drug Coverage history. <input type="checkbox"/> <b>I.</b> Notice of LEP amount reported to Part D plan by CMS <input type="checkbox"/> <b>J.</b> Creditable Prescription Drug Coverage Notice [Note: this could be from any prior plan so we suggest deleting the RDS reference] <input type="checkbox"/> <b>K.</b> Evidence of Special Circumstances (such as proof an enrollee lived abroad and did not reside in a Part D service area after his/her Part D initial enrollment period) <input type="checkbox"/> <b>L.</b> Part D Plan Evidence of Coverage or other Subscriber Materials (relevant portions)