



**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): _____

Appellant Name	Enrollee Name

Enrollee HIC/Medicare Claim Number	Date of Birth

Enrollee Address and Phone Number:

Enrollee requires the Reconsideration Notice in a language other than English?

___ No ___ Yes Language: _____

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.	
Procedural Documents	<ul style="list-style-type: none"> <input type="checkbox"/> A. 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. Beneficiary Attestation of Creditable Coverage <input type="checkbox"/> C. Letter Informing Beneficiary of LEP <input type="checkbox"/> D. Representation Documents (AOR or other writing, DPOA/POA, Healthcare Proxy, Surrogate for an incompetent enrollee under State law, estate representative) <input type="checkbox"/> E. Other (describe or list below additional exhibits the Plan considers important) <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>
Evidentiary Documents	<ul style="list-style-type: none"> <input type="checkbox"/> F. Application for Enrollment in Part D Plan <input type="checkbox"/> G. Notice Informing Beneficiary of Part D Enrollment Effective Date <input type="checkbox"/> H. BEQ/MARx Screen verifying enrollee's Part D Entitlement and Part D Plan Enrollment and Creditable Prescription Drug Coverage history. <input type="checkbox"/> I. Notice of LEP amount reported to Part D plan by CMS <input type="checkbox"/> J. Creditable Prescription Drug Coverage Notice [Note: this could be from any prior plan so we suggest deleting the RDS reference] <input type="checkbox"/> K. 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"/> L. Part D Plan Evidence of Coverage or other Subscriber Materials (relevant portions)