Part D Late Enrollment Penalty (LEP) Reconsideration Request Form

Please use one (1) Reconsideration Request Form for each Enrollee.

Date: _____ **Medicare Appeal #** _____
(For MAXIMUS Federal Services use only)

Enrollee Name: _____

Address: _____

City, State, Zip Code: _____

Phone: (_____) _____

Medicare number: _____
(From red, white and blue Medicare card)

Date of Birth (MM/DD/YYYY): _____

Name of current Part D Drug Plan: _____

IMPORTANT: A signature by the enrollee is required on this form in order to process an appeal.
Complete, sign and mail this request to the address at the end of this form, or fax it to the number listed on the form within 60 days from the date on the letter you received stating you have to pay a late enrollment penalty. If it has been more than 60 days, explain your reason for delay on a separate sheet and send it with this form.

Check all boxes that apply to you (your case will only be reviewed for one or more of the following reasons):

☐ **I had other prescription drug coverage** as good as Medicare's (creditable coverage). Please provide evidence of prior creditable prescription drug coverage. For example:

- If you had drug coverage from an employer or union plan, provide a copy of the Notice of Creditable Prescription Drug Coverage or Certificate of Prior Creditable Prescription Drug Coverage from the employer or union plan.
- If you had drug coverage with the Department of Veterans Affairs (VA), please provide any of the following: Notice of Creditable Prescription Drug Coverage; a copy of your VA Health Benefit Card; a letter from the VA certifying eligibility; or an Explanation of Benefits (EOB).
- If you have drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian Organization (I/T/U), please provide a copy of any of the following: IHS registration card; letter verifying eligibility and/or enrollment.

Name of former employer/union/other insurer: _____

Dates of coverage (mm/dd/yyyy) from _____/_____/_____ to _____/_____/_____

Plan Address & Phone: _____

Contact Name: _____ Phone: _____

☐ I had prescription drug coverage but **I didn't get a notice that clearly explained if my drug coverage was creditable** coverage.

Reminder: Most non-Medicare plans that offer prescription drug coverage, like employer or union coverage, must send enrollees a notice explaining how their prescription drug coverage compares to Medicare prescription drug coverage. Plans may provide this information in their benefits handbook or as a separate written notice.

If you don't know if your prescription drug coverage was creditable:
To help your case, you may want to send a letter to your previous plan and ask if your coverage was creditable. Attach your letter and any response to this form. You shouldn't wait to receive a response before you send this request form, and there is no need to send a letter if your prior coverage was with a Medicare Part D plan.

☐ **I believe the LEP is wrong because I was not eligible to enroll in a Medicare Part D plan during the period stated by my current Medicare Part D plan.** Example: You lived outside of the United States during the initial enrollment period stated by your Medicare Part D plan. You must submit proof why you believe the LEP is wrong, such as proof of overseas residency.

☐ **I believe the LEP is wrong because I was unable to enroll in a Medicare Part D plan due to a serious medical emergency.** You must submit proof that you experienced a serious medical emergency (e.g. unexpected hospitalization) that affected your ability to timely enroll in a Medicare Part D plan.

☐ **I have/had Extra Help from Medicare to pay for my prescription drug coverage.**

- **Dates of Extra Help: from _____ to _____.**
- **Use a separate sheet if necessary.**

☐ **I lived in an area affected by Hurricane Katrina** at the time of the hurricane (August 2005) and I joined a Medicare drug plan before December 2006.

- I am attaching evidence of my residency in 2005.
- Name of Parish: _____

By signing this form, I give permission to any entity to release information needed by Medicare or its independent contractor (MAXIMUS Federal Services) to review my Medicare Part D late enrollment penalty appeal.

I certify that the information on this form is true, accurate and complete. I understand that if I have submitted any false documents, made any false claims or statements, or concealed any material facts, I may be subject to civil or criminal liability.

_____ _____
Signature of Enrollee **Date**

• Be sure to include your Medicare Health Insurance Claim number on any materials you send.
• Do not send original documents.
• Please make sure the enrollee and representative, if applicable, have signed this form.

Send this form and any extra pages to:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 704
Pittsford, NY 14534-1302
Fax number: (720) 462-7578
Toll Free fax number: (866) 589-5241

Note about Representatives:
If you want another individual, such as a family member, friend, or your doctor to request a reconsideration for you, that individual must be your representative.

[*For HMO*:
<CarePartners of Connecticut is an HMO plan with a Medicare contract. Enrollment in CarePartners of Connecticut depends on contract renewal.>]

[*For PPO*:
<CarePartners of Connecticut is an PPO plan with a Medicare contract. Enrollment in CarePartners of Connecticut depends on contract renewal.>]