Part D Late Enrollment Penalty (LEP) Reconsideration Request Form Date:

Date: ____

Enrollee's Name: ____

Address: ____

____

Phone: (   ) ____________________________

Medicare Number: ________________________________
(From your red, white, and blue Medicare card)

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.

Your case will ***only*** be reviewed for one or more of the following reasons. **Check all of the boxes below that apply to you.**

______**I had other creditable prescription drug coverage.** Please complete the following (use a separate sheet, if necessary):

Plan name: ____
Date of coverage (mm/dd/yyyy) from____/_____/_____to______/______/______
Plan address and phone: ____
____
Name of former employer/union/other insurer: __________________________
Contact name:______________________________Phone:___________________

Send any additional information that may help your case. If possible, please provide evidence of prior "creditable*" prescription drug coverage. Examples of "creditable coverage" include:

- 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 plan.

- If you had drug coverage with the Department of Veterans Affairs (VA) – 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).

**Creditable means your prior coverage met Medicare's minimum standards*

______I had prescription drug coverage, but didn't get a notice that clearly explained if my drug coverage was creditable.

- *REMINDER*: Most non-Medicare plans that offer prescription drug 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. These plans include employer or union coverage.
- Also, the "certificate of creditable coverage" that you may have received when your health coverage ended doesn't mean that your prescription drug coverage was as good as Medicare's standard prescription drug coverage - unless the notice specifically mentioned that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
- If you don't know if your prescription drug coverage was creditable, you might want to send a letter to your previous plan and ask if your coverage with them was creditable. Attach a copy of your letter and their response when you send back this form. Make sure you also include any other information you got from your prior plan that describes your prescription drug coverage for the months you're being charged an LEP.
- Prescription drug coverage is **insurance**. It's NOT doctor samples, discount cards/programs, free clinics, or drug discount websites.

______ I wasn't eligible to enroll in a Medicare drug plan during the period stated by my current Medicare drug plan.

- For example: You lived outside the United States during your initial enrollment period.
- You must submit proof, such as proof of overseas residency.

_______ I couldn't enroll in a Medicare drug 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 or had Extra Help from Medicare to pay for my prescription drug coverage.

- Date(s) of Extra Help from___________to____________.
- Attach a separate sheet, if needed.

_______I lived in an area affected by Hurricane Katrina at the time of the hurricane in August 2005 and joined a Medicare drug plan before Dec. 31, 2006.

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

To the best of my knowledge, the information on this form is true and correct. I understand that my signature (or the signature of my representative) on this document means I have read and understand the contents of this request. By signing this form, I give permission to any entity to release information needed by Medicare to review my Medicare prescription drug late-enrollment penalty.

____ _______________

Enrollee or representative signature Date

By signing this form, I give permission to any entity to release information needed by Medicare or its independent contractor (<C2C Innovative Solutions, Inc>) 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.

IMPORTANT NOTE ABOUT REPRESENTATIVES: If you want another person, such as a family member, friend, or doctor to request reconsideration for you, that person must be your representative. Call Humana at 1-800-457-4708 to find out more about naming a representative.

COMPLETE THIS SECTION ONLY IF THE PERSON MAKING THE REQUEST ISN'T THE ENROLLEE:
Representative name: ____
Relationship to enrollee: ____
Address:____
Phone: ______________________________
Attach documentation that shows authority to represent enrollee, such as Form CMS-1696.

REMINDER: Mail or fax this form and any additional information to <C2C> (Medicare's Appeals Contractor). Remember to include your Medicare number on any materials you send. **Don't** send original documents.

C2C Innovative Solutions, Inc.
Part D LEP Reconsiderations
P.O. Box 44165
Jacksonville, FL 32231-4165
Fax number: (833) 946-1912
Customer Service: (833) 919-0198

If you need more information, visit <C2C's> website at <www.partdappeals.c2cinc.com>, or call Humana at the number on the back of your ID card. You can call Monday-Friday from 8 a.m. to 8 p.m.

Our automated phone system may answer your call after 8 p.m. and on Saturdays, Sundays, and some holidays. Please leave your name and telephone number. Your call will be returned by the end of the next business day.

STOP! DID YOU SIGN THIS FORM?