

MODEL Part D Late Enrollment Penalty Reconsideration Notice

YOUR RIGHT TO ASK MEDICARE TO REVIEW YOUR MEDICARE PART D LATE ENROLLMENT PENALTY

“Creditable prescription drug coverage” is coverage (for example from an employer or union) that meets Medicare’s minimum standards since it is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. If you don’t join a Medicare drug plan when you are first eligible, and you don’t have other “creditable prescription drug coverage,” you may have to pay a late enrollment penalty (LEP).

What if I Don’t Agree with Medicare’s Late Enrollment Penalty Decision?

In some cases you have the right to ask Medicare to review your late enrollment penalty decision. This is called a “reconsideration.” For example, you could request a reconsideration if you think Medicare did not count all of your creditable coverage or if you didn’t get a notice that explained whether your previous prescription drug coverage was creditable. Other reasons for requesting a reconsideration are listed on the request form sent with this notice.

Who Can Ask for a Reconsideration?

You or someone you name to act for you (your representative) can ask for a reconsideration. If someone requests a reconsideration for you, he or she must send proof of his or her right to represent you with the request form. Proof could be a power of attorney form, a court order, or an “Appointment of Representative” form. This last form can be found at <https://www.medicare.gov/forms-help-resources/medicare-forms>. You also can call the Medicare helpline (see below) and ask for Form CMS-1696.

How Do I Ask for a Reconsideration?

Complete the reconsideration request form sent with this notice. Mail it to the address or fax it to the number listed on the form within 60 days from the date on the letter you got stating you had to pay a late enrollment penalty. You should also send any proof that supports your case, like information about previous creditable prescription drug coverage. If you wait more than 60 days, you must explain why your request is late. Medicare will decide if you had good cause to send a late request.

What Do I Need to Include with My LEP Reconsideration Request?

1. A completed, signed LEP reconsideration request (keep a copy).
2. Copies of information you believe may help your case.
3. If you’ve named someone to act for you, a copy of the proof the individual can represent you.

NOTE: Do not send original documents.

Where Can I Get More Information?

Call UCLA Health Medicare Advantage Plan (HMO) at (833) 627-8252 (833-MAP-UCLA) April 1st through September 30th 8am - 8pm PST, Monday – Friday Closed: All Federal Holidays. October 1st through March 31st 8am - 8pm PST, 7 days a week Closed: Thanksgiving and Christmas Day. TTY users should call the plan at 711 Toll Free 800-735-2929 Voice 800-735-2922. www.UCLAhealthmedicareadvantage.org/members

Or, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) for help. TTY users should call Medicare at 1-877-486-2048.

UCLA Health Medicare Advantage Health Plan (HMO) has a contract with Medicare and enrollment in the plan depends on contract renewal.

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You can obtain this document for free in non-English languages or other formats, such as large print, braille or audio. Call UCLA Health Medicare Advantage Plan (HMO) Customer Service toll free: (833) 627-8252 (833-MAP-UCLA) (TTY 711). The call is free.

Part D Late Enrollment Penalty (LEP) Reconsideration Request Form

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

Date: _____ Medicare Appeal # _____
(For C2C Innovative Solutions, Inc. 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 (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.

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:

Standard Mail:

C2C Innovative Solutions, Inc.
Part D LEP Reconsiderations
P.O. Box 44165
Jacksonville, FL 32231-4165

Courier or Tracked Mail:

C2C Innovative Solutions, Inc.
Part D LEP Reconsiderations
301 W. Bay St., Suite 600
Jacksonville, FL 32202

Toll Free fax for enrollees: (833) 946-1912

Web Portal Address: <https://www.c2cinc.com//Appellant-Signup>

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.

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