Medicare Appeal #:_		
	(For C2C use only)	

# Part D Late Enrollment Penalty (LEP) Reconsideration Request Form

	ase use one (1) Reconsideration Requeste:			
	rollee Name:First Name	Last Name		
		_ City:		
Sta	te:	Zip Code:		
Pho	one: ()	_		
Ме	dicare Number:			
Dat	te of Birth (MM/DD/YYYY):			
Nar	me of current Part D Drug Plan:			
sigi with	n and mail this request to the address at the nin 60 days from the date on the letter you r	equired on this form in order to process an appeal. Complete, e end of this form, or fax it to the number listed on this form received stating you have to pay a late enrollment penalty. If i son for delay on a separate sheet and send it with this form.		
Ch	eck all boxes that apply to you:			
	I had other prescription drug coverage as g	good as Medicare's (creditable coverage).		
Please provide evidence of prior creditable prescription drug coverage. For example:				
		employer or union plan, provide a copy of the Notice of age or Certificate of Prior Creditable Prescription Drug on plan.		
	any of the following: Notice of Credi	the Department of Veterans Affairs (VA), please provide itable Prescription Drug Coverage; a copy of your VA Health ertifying eligibility; or an Explanation of Benefits (EOB).		
		the Indian Health Service, a Tribe or Tribal organization, or I), please provide a copy of any of the following: IHS gibility and/or enrollment.		
	Name of former employer/union/other ins	urer:		
	Dates of coverage (MM/DD/YYYY) from_	to		
	Plan Address & Phone:			
	Contact Name:			
	I had prescription drug coverage but I didn creditable coverage.	n't get a notice that clearly explained if my drug coverage was		
	coverage, must send enrollees a notice ex	offer prescription drug coverage, like employer or union explaining how their prescription drug coverage compares to may provide this information in their benefits handbook or		

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# 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.

2	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 seriou 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: fromto			
	Use a separate sheet if necessary.			
By signing this form, I give permission to any entity to release information needed by Medicare or its ndependent 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.				

 Be sure to include your Medicare Health Insurance Claim number or Medicare Beneficiary Identifier on any materials you send.

Date

- · 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:

Signature of Enrollee

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.

Complete the attached Appointment of Representative form only if you wish to have another individual represent you for this appeal.

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# **Appointment of Representative**

Name of Party	ty Medicare Number (beneficiary as party) or Nation Provider Identifier (provider or supplier as party)	
Section 1: Appointment of Representative To be completed by the party seeking representation (i.e. I appoint this individual,	et as my representative in correlated provisions of Title XI et; to obtain appeals information in my stead. I understand the	nnection with my claim or asserted of the Act. I authorize this on; and to receive any notice in
Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		
I,, hereby accept the above a suspended, or prohibited from practice before the Department current or former employee of the United States, disqualified that any fee may be subject to review and approval by the Se I am a / an (Professional status or relationship to the par	t of Health and Human Servi rom acting as the party's rep cretary.	ces (HHS); that I am not, as a presentative; and that I recognize
Signature of Representative	ty, o.g. automoy, rolauvo, oto	Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		
Section 3: Waiver of Fee for Representation Instructions: This section must be completed if the representation. (Note that providers or suppliers that are representation and charge a fee for representation and must complete to a waive my right to charge and collect a fee for representing	resenting a beneficiary and f	
Signature		Date
Section 4: Waiver of Payment for Items or Service Instructions: Providers or suppliers serving as a represenservices must complete this section if the appeal involves (Section 1879(a)(2) generally addresses whether a provider/sexpected to know, that the items or services at issue would not from the beneficiary for the items or services at issue in this a is at issue.  Signature	ntative for a beneficiary to s a question of liability und upplier or beneficiary did not of be covered by Medicare.)	der section 1879(a)(2) of the Act. tknow, or could not reasonably be I waive my right to collect payment

# Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee **must** be waived for representation

# **Approval of Fee**

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

## **Conflict of Interest**

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

## Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit <a href="https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html">https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html</a>, or call 1-800-MEDICARE (1-800-633-4227) for more information.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-1696 (Rev 08/18)