# MED D - Obtaining a Verbal Attestation from an Authorized Representative

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**Description:** This document provides the steps for obtaining a Verbal Attestation from an Authorized Representative.

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| Overview |

When a plan does not have documentation on file for a POA or Authorized Representative, a caller may provide a verbal attestation that they are able to make a request on behalf of the beneficiary in certain scenarios. However, the caller should always be encouraged to send the Plan this documentation or a verbal attestation must be completed each time the caller contacts the plan with a request.

Verbal Attestation can **ONLY** be accepted for the following **Enrollment/Disenrollment** scenarios:

* Address Changes
* New Plan Enrollments or Missing Information
* Disenrollment
* TRC 127 Attestations
* LEP Attestations
* Prospective Enrollee

 All other scenarios require AOR/POA documentation is on file with the plan. Refer to [MED D - Appointed Representative Form (AOR) or Power of Attorney (POA)](file:///C:\Users\ax02205\Desktop\Document\Med%20D%20General\Working%20Documents\AOR\CMS-2-021424).

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| Process |

Perform the steps below with the approved talk tracks:

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| **Step** | **Action** | | |
| **1** | * In order to protect the privacy of the beneficiary, the plan requires a Power of Attorney to be on file in order to discuss/disclose any PHI on the account. * Appropriate legal documentation along with the following information can be mailed to the plan.   + Beneficiary’s first and last name   + Beneficiary ID as it appears on the Member ID card   + Beneficiary’s address and phone number   + A copy of the Power of Attorney or other legal documentation that indicates the Name and identifying information of the person authorized to act on behalf of the beneficiary for health care purposes   + First and last name   + Address   + Telephone number   **Turn Around Time Notes:**   * To mail form to beneficiary = 3 business days * To process once received = 10 business days * Refer to [MED D - Appointed Representative Form (AOR) or Power of Attorney (POA)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=4008954a-0d95-4ea9-add2-3a7dfa02c718). | | |
| **Client** | **Address** | |
| **SilverScript** | **SilverScript Insurance**  **PO Box 30001**  **Pittsburgh, PA 15222-0330**  **FAX: 1-866-552-6205**  **Note:** A copy of the Power of Attorney or other legal documentation is acceptable even if the document contains a raised seal (happens in court orders, etc). | |
| **Blue MedicareRx (NEJE)** | **Blue Medicare Rx**  **PO Box 30001**  **Pittsburgh, PA 15222-0330**  **FAX: 1-866-342-7048**  **Note:** A copy of the Power of Attorney or other legal documentation is acceptable even if the document contains a raised seal (happens in court orders, etc). | |
| **All Other Clients**  (EGWP/HealthPlan) | **CVS Caremark**  **PO Box 30001**  **Pittsburgh, PA 15222-0330**  **FAX: 1-866-552-6205**  **Note:** A copy of the Power of Attorney or other legal documentation is acceptable even if the document contains a raised seal (happens in court orders, etc). | |
| **2** | Obtain and notate the following information:   1. Legally Authorized Representative’s First and Last Name. 2. What is the best phone number to reach you if documents are requested? (XXX) XXX-XXXX 3. Please provide your full mailing address (street address, city, state, zip code + 4 if available). 4. What is your relationship to the enrollee? | | |
| **3** | * In order to protect the privacy of the beneficiary, I will need to ask you a few questions to proceed with the call. * Are you authorized under state law to update this information or do you have Power of Attorney for our beneficiary? * Is documentation of this authority available upon request by SilverScript/Blue MedicareRx (NEJE) or by Medicare? | | |
| **If...** | | **Then...** |
| **Yes** to both questions | | Proceed to next step. |
| **No** to either or both questions | | Inform the caller that requests for changes to the beneficiary’s account can only be accepted from the beneficiary or individuals authorized to act on behalf of the beneficiary. |
| **4** | In order to accept the information I have obtained from you, I will require a verbal signature to show that you are attesting that the information provided on this call is true and correct to the best of your knowledge. Please state **Yes** if you attest to the verbal signature. (Must include Yes or No). | | |

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| Related Documents |

Grievance Standard Verbiage (for use in Discussion with Beneficiary) section in [MED D - Grievances Index](TSRC-PROD-007931).

**Parent SOP:** CALL-0048: [Medicare Part D Customer Care Call Center Requirements-CVS Caremark Part D Services, L.L.C.](https://policy.corp.cvscaremark.com/pnp/faces/SecureDocRenderer?documentId=CALL-0048&uid=pnpdev1)

**Abbreviations/Definitions:** [Abbreviations / Definitions](CMS-2-017428)

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