# Compass MED D - Initiate Coverage Determinations from Claim Results

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**Description:** Provides the CCR with steps for submittinga Med D Coverage Determination request from a rejected claim or from the Test Claim results screen for the following reasons: Formulary Exception (Non formulary and Med D excluded), Redetermination (Appeals), Tiering Exception, Prior Authorization, Step Therapy Exception, Quantity Limit Exception, B vs. D Prior Authorization, Drug Excluded by Part D Law.

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| Important Information |

Although a MED D plan has a specific formulary of covered medications, MED D Beneficiaries can ask the plan to cover medications not included on the formulary or drugs that are on the formulary but have predetermined criteria.

* These initial requests are called Coverage Determinations.

If a Beneficiary disagrees with the plan's decision, there are five (5) levels of appeals available to try to obtain coverage of medications.

* However, PBMs handle only the first level of appeals, also known as a Redetermination.

 Please refer to the CIF for direction on the proper team to assist with CD&A questions.

**Notes:**

* Do NOT proactively offer Tiering or Formulary Exceptions unless otherwise directed in the document.
* There may be two lines of eligibility visible for migrating plans and in some cases, a transfer to a different Customer Care group may be required - check the CIF for the correct process.

Unless otherwise noted, all phone numbers provided throughout the document are **internal only and should not** be provided to callers.



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| Provider Calls |

Proceed depending on what the provider is calling for:

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| **If the provider is calling for…** | **Then…** |
| * Formulary alternatives for a non-formulary medication * Lower cost alternatives for a formulary medication | Proceed to the [Process](#_Process_1) section. |
| A Coverage Determination or Appeal | Warm transfer to **1-877-827-7315** andselect **prompt 2**.  **Notes:**   * Do not provide the above telephone numbers to a beneficiary. They are for provider calls only. For beneficiary calls, refer to [Process](#_Process_1). * For CD&A hours of operation, refer to [Phone Numbers (Contacts, Departments, Directory, Addresses, Hours and Programs) (004378)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=f22eb77e-4033-4ad9-9afb-fc262f29faad). * If after hours, Customer Care must submit a Coverage Determination request. Proceed to the [Process](#_Process_1) section. |

**Note:** If the beneficiary is calling to advise of a change to the provider for an in-process CD request, refer to the “Transfer to Coverage Determination (Escalations and Senior Team Only)” section of [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff).

**Reminder:** Refer to [HIPAA Grid (028920)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5b354e50-0d15-42d0-b9c2-0711ea02d9ce) to ensure prescriber/provider guidelines are followed.

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| Process |

May vary by client; always refer to the CIF.

**Note:** Please review the **Member’s Recent Support Task** panel in the **Case Details** tab and the **Override/PA History** link to confirm a CD&A request is not already in process for the same medication.

Each medication requested will require a separate Coverage Determination.



Follow the steps below to Initiate a Coverage Determination through Automation:

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| **Step** | **Action** | | | |
| **1** | Authenticate and identify the caller. | | | |
| **If the caller is…** | | | **Then…** |
| Beneficiary or Beneficiary representative (POA or AOR on file) | | | Caller **does** want to initiate the request now:   * Proceed to the next step.   Caller **does not** want to initiate request now:     * I understand. * Please feel free to contact us at your earliest convenience 24 hours a day, 7 days a week. * You can find the number on the back of your ID card.   + **Process Note:** Look up the specific client Care number on the CIF. * Completed Coverage Determination forms can also be faxed or mailed to:   **Fax:**  MED D Coverage Determination and Appeals (CD&A)  Fax #: **1-855-633-7673**    **Mail:**  CVS Caremark Part D Services  Coverage Determinations & Appeals  P.O. Box 52000  MC109  Phoenix, AZ 85072-2000   * You may also utilize the plan's website, which contains a Coverage Determination request form and tells you how to submit the request electronically, if you prefer. |
| Physician or Provider | | | Caller **does** want to initiate the request now:   * Proceed to the next step.   Caller **does not** want to initiate request now:     * I understand. * Please feel free to contact us at your earliest convenience. * You can contact MED D Coverage Determination and Appeals (CD&A) for Coverage Determination requests at **1-877-827-7315 and select prompt 2**.   **CCR Note:** Please do not provide the above telephone numbers to a beneficiary. They are for provider and prescriber calls only.   * Completed Coverage Determination forms can also be faxed or mailed to:   **Fax:**  MED D Coverage Determination and Appeals (CD&A)  Fax #: **1-855-633-7673**    **Mail:**  CVS Caremark Part D Services  Coverage Determinations & Appeals  P.O. Box 52000  MC109  Phoenix, AZ 85072-2000   * You may also utilize the plan's website, which contains a Coverage Determination request form and tells you how to submit the request electronically, if you prefer. |
| **2** | Perform a test claim. Refer to: [Compass - Test Claims (050041)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=60c20ea0-1d07-46e3-809a-b54734b80fbe). | | | |
| **3** | Review Test Claim Results in the **Mail Status** column and/or the **Retail Status** Column. | | | |
| **If test claim result is...** | **Then…** | | |
| Accept | Coverage Determination is not required unless beneficiary expresses concern about the cost of the medication, then a tiering exception can be requested. If beneficiary requests, proceed to [Step 4](#ProcessStep4). | | |
| Denied | 1. Click the Reject Code hyperlink located in the **Mail Messages** or **Retail Messages** column of the denied claim.     **Result:** Messaging for <drug information> displays.   1. Review **Reject Messages** and click **Continue** to display the Simulate Override/PA for <drug information> pop-up message.      1. Review the Simulate Override/PA for <drug information> pop-up message and click **Confirm** to populate the **Mail Mbr. Pay** column of the previous test claim as if it were a paid claim or had an approved PA/CD&A.     **Notes:**   * Selecting the Reject Code hyperlink in the Mail Messages column will populate the **Mail Mbr. Pay** column only. * Selecting the Reject Code hyperlink in the Retail Messages column will populate the **Retail Mbr. Pay** column only. * Both may be performed by using the same test claim. | | |
| **4** | Initiate a Coverage Determination by Automation. Refer to [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff) as needed. | | | |
| **If Reject Reason is for…** | | **Then…** | |
| * **Formulary Exception**    + **Non formulary**   + **Med D excluded** * **Redetermination and Appeals** (Initial CD&A has already been submitted and denied) * **Tier Exception** * **Prior Authorization** * **Step Therapy Exception** * **Quantity Limit Exception** * **B vs. D Prior Authorization** * **Drug Excluded by Part D Law** | | Proceed to the next step (Automation). | |
| **5** | From the Test Claim Results screen, click the **Row Level Action** drop-down arrow and select **Initiate Coverage Determination**.  **Notes:**   * If CVS/Caremark does not handle the plan’s Coverage Determinations, the Initiate Coverage Determination option will be disabled. * The Initiate Coverage Determination option will be available whether the test claim is accepted or denied.     **Result:** The Coverage Determination screen displays. | | | |
| **6** | Review Alternatives in the **Confirm Alternatives Have Been Reviewed** section.   * **If Alternatives display,** provide the beneficiary with formulary alternatives and advise the beneficiary to consult with their provider, then select the checkbox next to each medication discussed with the caller.   **Notes:**   * Only Alternatives that are on the beneficiary’s formulary will display. * Mail availability indicator will be available when viewing alternatives * If the beneficiary insists they do not want to hear alternatives, select the **Caller declined to discuss alternatives** checkbox. * Only one Alternative needs to be selected to proceed with the Coverage Determination.     There are formulary alternative medications on the formulary that may be appropriate for your treatment. Additionally, formulary alternatives can reduce your annual drug spend, can be cheaper than your current medications and you can possibly obtain the medication quickly.  Here are some examples of formulary alternatives available to you <provide alternatives listed in the Compass Test Claim Results Screen>.  If your provider feels the drug prescribed is best for you, your provider can complete the form necessary to request your Coverage Determination.  Would you like to start by asking your provider to review our list of covered drugs to determine if there are alternate drugs on the formulary that are appropriate for your treatment?   * **If no Alternatives display in the** **Confirm Alternatives Have Been Reviewed** section, then a message will display: “There are no alternatives to review with the caller.” Proceed to the next step.   I’m unable to identify any formulary alternative medications within the resources that I have.  **Note:** If no alternatives are listed or if the beneficiary has clinical questions about the alternative, you can offer to transfer to the Clinical Care Services Team at **1-866-251-3591, Option 2** to discuss the alternatives or to validate no alternatives are available.    **Notes:**   * Selecting medication(s) in the **Confirm Alternatives Have Been Reviewed** section indicates you have offered the medication to the caller, but the caller did not accept the alternative. * If medication is **Specialty**,an icon will display next to the drug name/strength. * To select all medications in the **Confirm Alternatives Have Been Reviewed** list at once, click the checkbox next to the **Drug Name/Strength** heading. | | | |
| **7** | Select a **Coverage Determination Reason** from the drop-down menu:   * Formulary Exception (Non formulary and Med D excluded) * Prior Authorization * Quantity Limit Exception * Redetermination (Appeals) * Step Therapy Exception * Tiering Exception (No alternatives available or beneficiary expressed concerns with pricing)     **Result:** The **Identify Caller** section displays. | | | |
| **8** | Select who is calling from the **Identify Caller** drop-down menu.  **Note:** If the caller is not the beneficiary, doesn't have a POA/AOR on file, and isn't a Ship Counselor, refer to the [Scenario Guide](#_Scenario_Guide_1) below for additional information. | | | |
| **9** | Proceed depending on if the beneficiary is PDP SilverScript and the following **PDP SilverScript** section displays: | | | |
| **If…** | | **Then…** | |
| No | | Skip to [Step 11](#ProcessStep11).  Step 10 is **ONLY** applicable to **Tier Exception Exclusions** for specific clients, for all other clients the PDP Silverscript prompt will not appear. | |
| Yes | | Proceed to [Step 10](#ProcessStep10). | |
| **10** | Click the Tier Exception Exclusion List hyperlink, then select **Yes** or **No** depending on if the requested drug appears on the exclusions list.    **Note:** To change your selection, do NOT click the Cancel button. You can change the selection at any time by selecting the alternate option when needed. | | | |
| **If you select…** | | **Then…** | |
| Yes, the drug is on the Tier Exception Exclusion List | | The following talk track will display:  I’m sorry to inform you that this drug currently has no preferred alternatives and is not eligible to be moved to a lower tier or cost. It would be my pleasure to provide you with some information regarding financial assistance if you’d like. Refer to [Member Cannot Afford Medication (Alternatives and Financial Assistance) (026963)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=62aa67ac-8298-4fa1-b1ba-fda383d15b4c) as needed.  The **Financial Assistance** hyperlink in Compass will open the “Prescription Financial Assistance for Members” document in theSource.  **Note:** After reading the provided talk track, if the caller insists on receiving a tiering exception:   * Check the box for **Caller insists on a tier exception**.   **Result:** The **Verify Provider** button displays (enabled).   * Click the **Verify Provider** button.   **Result:** The Coverage Determination - Verify Provider screen displays.   * Skip to [Step 13](#ProcessStep13). | |
| No | | The **View Formulary in CIF** section displays. Proceed to Step 11. | |
| **11** | In the **View Formulary in CIF** section, click the **CIF** hyperlink to open the CIF in theSource. Refer to [Compass - Locating a CIF Using Auto Search (043888)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=d9bd0fe8-fbb2-490c-a03c-c9eb7db15a71) as needed.  Then review the information provided in theSource and select **Yes** or **No** depending on if the requested drug is listed on the beneficiary’s plan formulary.    **Note:** To change your selection, do NOT click the Cancel button. You can change the selection at any time by selecting the alternate option when needed. | | | |
| **12** | Educate the beneficiary on the Accumulations and PA Checks if applicable.  **Notes:**   * For assistance on Accumulations and PA refer to the [Scenario Guide](#ScenarioGuide). * Once the agent has completed all required steps, the Verify Provider button will be enabled.   Then click the **Verify Provider** button and proceed to the next step.  **Result:** The Coverage Determination - Verify Provider screen displays. | | | |
| **13** | Verify with the caller that the provider listed is correct for the medication in question.    **Notes:**   * If no results, the following message will display: “No provider selected.” * **Provider Search** button can be used to search for a new provider. * The **Create Coverage Determination Request** button will remain disabled until Provider is listed/verified. * Click the **Previous** button to returnthe **Coverage Determination** subtab main page. * To exit the request, click **Cancel**. | | | |
| **14** | Click the **Create Coverage Determination Request**.  **Result:**   * **Coverage Determination Request** page will display. * Coverage Determination requests can be either standard or expedited. Refer to [Compass MED D - CCR - Coverage Determinations and Redeterminations (Appeals) (064997)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a23bc09d-37f7-4105-ba57-d4e9d7f512ff) for details on turnaround times. * Please verify all information on the Coverage Determination Request page prior to submitting the request.     **Note:** If the request fails, refer to the [Submitting an Offline Support Task for CD&A](#_Submitting_an_Offline) section below. | | | |

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| Submitting an Offline Support Task for CD&A |

Follow the steps below to submit a Coverage Determination Support Task:

**Note:** This process will only be available when the automation fails.

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| **Step** | **Action** | |
| **1** | Verify that a Support Task should be created. | |
| **If Reject Reason is for…** | **Then…** |
| * Formulary Exception - Non formulary and Med D excluded * Redetermination and Appeals (Initial CD&A has already been submitted and denied) * Tier Exception * Prior Authorization * Step Therapy Exception * Quantity Limit Exception * B vs. D Prior Authorization * Drug Excluded by Part D Law | Confirm that automation has failed and you are unable to initiate a Coverage Determination through the Test Claim Results screen.   * If Compass automation failed, proceed to Step 2. * If you have not tried to initiate a CD through a rejected claim or the Test Claim Results screen, proceed to the [Process](#_Process_1) section above. |
| **2** | Click **Create CD&A Support Task**.  **Note:** Fields containing an asterisk (\*) are required.  A screenshot of a computer  AI-generated content may be incorrect.  **Result:** The New Support Task window displays. The support task will be populated with the information necessary to complete the task. | |
| **3** | Repeat the entire request back to the caller to confirm accuracy.    This is **mandatory** and is **required** to be performed.    Proceed to the next step. | |
| **4** | Submit the Support Task, then advise the caller that:   * The request has been sent to the MED D Coverage Determination and Appeals (CD&A) Team. * The **Beneficiary or Beneficiary's representative** will be notified of the decision by an automated phone call (if valid phone number is on file) and/or a letter in the mail. * The **provider** will be notified by a fax and/or a letter in the mail.   **Note:** Verify that an accurate phone number is on file and process an update if necessary.   * Refer to [Compass MED D - Address Changes and Out of Area (OOA) (061760)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a5cf7af0-8a89-45dc-a395-9961dceac183).   The time frames to complete the **Coverage Determination** process are:   * **Standard:** Up to **72 hours** from date/time of receipt of valid request, but exception requests may be up to **408 hours** (17 days) if a statement of medical necessity is needed from the Provider.   + This includes nights, weekends, and holidays. * **Expedited:** Up to **24 hours** from date/time of receipt of valid request, but exception requests may be up to **360 hours** (15 days) if a statement of medical necessity is needed from the Provider.   + This includes nights, weekends, and holidays.     The time frames to complete the **Redetermination** process are:   * **Standard Requests:** Decisions within **7 calendar days** from date/time of receipt of valid request.   + This includes nights, weekends, and holidays. * **Expedited Requests:** Decisions within **72 hours** from date/time of receipt of valid request.   + This includes nights, weekends, and holidays.     Proceed to the next step. | |

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| FAQs |

Refer to the table below:

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| **#** | **Question** | **Answer** |
| **1** | **What is a Prior Authorization and why is the plan requesting one?** | For certain prescription drugs, the beneficiary needs to get approval from the plan before the plan will agree to cover the drug. In order to start the review process, the beneficiary or HIS/HER prescriber must submit a Prior Authorization (PA) request. Drugs that require a PA are listed on the Formulary. This process is not intended to cause inconvenience, but rather to ensure medications receive the highest in safety and quality monitoring. It is not necessary to have a prescription on file to initiate a request for a formulary or non-formulary medication requiring a PA. |
| **2** | **Does a beneficiary need a prescription on file to process a Coverage Determination?** | No, a prescription does not determine or affect if a medication is covered by the plan. A prescription is needed to receive the medication from the pharmacy, but not to review a coverage determination. |
| **3** | **What about clients that handle their own CDAs. Will we continue to send to the plan or will the CCR initiate the Coverage Determination process?** | Any client that handles their own CDs would have the call transferred directly to them - the CCR would not initiate a Coverage Determination from a rejected claim or the Test Claim result screen or utilize the CD&A Support Task. |
| **4** | **In instances where beneficiary states dissatisfaction/concern about the price of a medication that is not on the lowest Tier or a Specialty Tier, would the CCR initiate the Coverage Determination process?** | Yes, the CCR should initiate the Coverage Determination process. Do not file a Grievance unless concerning the CD process, for example, amount of time for a decision to be made, speed of transfer, etc. |
| **5** | **What do I do if a medication rejects 70 and 76?** | Refer to the document above and follow the steps for reject 70. |

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| Scenario Guide |

Refer to the following scenarios as needed:

[Identify Caller:](#_Toc207365825)

[Provider/Prescriber](#_Toc207365826)

[Family Member/Third Party](#_Toc207365827)

[All Other Caller Types](#_Toc207365828)

[Accumulations Check:](#_Toc207365829)

[Deductible](#_Toc207365830)

[Initial](#_Toc207365831)

[Catastrophic -TrOOP has been met](#_Toc207365832)

[PA Check:](#_Toc207365833)

### Identify Caller:

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| **Who is calling?** | **Action** |
| Provider/Prescriber | * Check the **phone number directory** hyperlink for Coverage Determination & Appeals (CD&A) team hours. * **Question:** Is it after hours for the Coverage Determinations & Appeals (CD&A) team?   + If the **No** radio button is selected, transfer to the CD&A team.     - Click the **Close** button.   + If the **Yes** radio button is selected, the **Verify Provider** button will dynamically display in the bottom right corner. * Click the **Verify Provider** button and proceed to [Step 13](#ProcessStep13) in the **Process**. |
| Family Member/Third Party | * Verify Beneficiary is present on the call, and select the applicable radio button **Yes**/**No**.   + If **Yes**, proceed to [Step 9](#ProcessStep9) in the **Process**. * Select **Family Member/Third Party** from the **Who is Calling?** drop down.   + Add the caller’s name in the **Requestor Name** field.      * If the beneficiary is available to speak select the radio button **Yes**.      * If the beneficiary is not available to speak and authorize the caller, select **No** and click on the **Check Privacy Records** hyperlink to review the privacy records. Once reviewed return to the **Coverage Determination Request**. If there is a POA/AOR on file for the caller select **Yes**.      * If **No** is selected, advise the caller:   “Only the member has the right to file a Coverage Determination or an Appeal unless there is a power of attorney (POA) or appointment of representative (AOR) on the account. If you would like, I can send you the AOR form. Or I can give you an address or fax number to send in a POA document.”   * + Links to POA/AOR information are available below the message.   **Note:** If the caller insists on a coverage determination, you may check the **Caller insists on a coverage determination** box and continue.     * Click the **Verify Provider** button and proceed to [Step 13](#ProcessStep13) in the Process.W |
| All Other Caller Types | * Verify Beneficiary is present on the call, then select the applicable radio button **Yes**/**No**.   + If **Yes**, proceed to [Step 8](#ProcessStep8) in the **Process**.   + If **No**, **Check Privacy Records** displays. * Verify POA or AOR is on file and select the applicable radio button **Yes**/**No.**   + If **Yes**, proceed to [Step 8](#ProcessStep8) in the **Process**.   + If **No**, read the caller the suggested verbiage displayed:   “Only the member has the right to file a Coverage Determination or an Appeal unless there is a power of attorney (POA) or appointment of representative (AOR) on the account. If you would like, I can send you the AOR form. Or I can give you an address or fax number to send in a POA document.”   * If caller insists on submitting a coverage determination, click the **Caller insists on a coverage determination** checkbox. * Click the **Verify Provider** button and proceed to [Step 13](#ProcessStep13) in the Process. |

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### Accumulations Check:

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| **Current Phase** | **Action** |
| Deductible | No action to take. |
| Initial | No action to take. |
| Catastrophic -TrOOP has been met | * Verify Beneficiary is experiencing the catastrophic phase, and select the applicable radio button: **Yes**/**No**. * If **Yes**, read the caller the suggested verbiage displayed:   “You are in your catastrophic stage of coverage. This means that a tier exception does not apply during this stage because drug cost is based on generic versus brand.”   * If caller insists on submitting a coverage determination, click the **Caller insists on a coverage determination** checkbox. * Click the **Verify Provider** button and proceed to [Step 13](#ProcessStep13) in the Process. |

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### PA Check:

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| **Action** |
| * If the **PA(s)** on file are **not** relevant to the beneficiary’s issue, select the checkbox “None of the PAs are relevant to the member's current issue”, then click **Verify Provider** and proceed to [Step 13](#ProcessStep13) in the Process.       **Notes:**   * If no Prior Authorization on file, **PA Check** section will display message “No PA's on file”. * Clicking the PA **ID** hyperlink will open the PA popup.   + To exit, agent can select the '**X**' button at the top right of the modal or the **Cancel** button. |

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| Related Documents |

* [MED D - Appointment of Representative (AOR) form (096099)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=577a556f-330c-4ea1-b1c6-200d85b736cf)
* [Medicare Prescription Drug Coverage and Your Rights (018576)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ca887eaf-6d6b-4d2a-be9e-90d80b1c77cb) (018576)
* [MED D - Grievance vs. Coverage Determination - Decision Matrix (027480)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=06e8f82d-e7b7-4a60-9c81-3bf7c37aadbf) (027480)
* [MED D - Coverage Determination Requests for 2025 (069924)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=2c7ceccc-bde6-4ec4-87d8-de77a64c7697)

**Parent Document:** 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/DocRenderer?documentId=CALL-0048)

**Abbreviations/Definitions:** [Customer Care Abbreviations, Definitions, and Terms Index (017428)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c1f1028b-e42c-4b4f-a4cf-cc0b42c91606)

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