Part D Late Enrollment Penalty (LEP) Reconsideration Request Form

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

Date: 01/03/2024 Medicare Appeal #: _____
(For MAXIMUS Federal Services use only)

Enrollee Name: Wylie P Duke

Address: PO Box 657, 12495 McKinley Trail

City, State, Zip code: Indianola, Iowa, 50125

Phone: (515) 326-1137

Medicare Number:
(From red, white and blue Medicare card): 8UF3H92TH79

Date of Birth (MM/DD/YYYY): 02/16/1953

Name of current Part D Drug Plan: Wellcare Value Script (PDP)

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 this 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:

☒ 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/have 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: Wells Fargo NA

Dates of coverage (MM/DD/YYYY) from 04/01/2006 to _____

Plan Address & Phone: Aetna, Narrow Network Copay Plan

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 (MAXIMUS Federal Services) 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.

_____ 01/03/2024

Signature of Enrollee Date

- Be sure to include your Medicare Health Insurance Claim number or Medicare Beneficiary Identifier 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:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 704
Pittsford, NY 14534-1302
Fax for enrollees: (720) 462-7578
Toll Free fax for enrollees: (866) 589-5241

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.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date 01/03/2024
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 representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

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 https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.
